AN ANALYSIS OF COPING PATTERNS OF ADULT TERMINAL CANCER PATIENTS

AN ABSTRACT

SUBMITTED TO THE FACULTY OF THE SCHOOL OF EDUCATION

ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

BY

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SCHOOL OF EDUCATION

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AN ANALYSIS OF COPING PATTERNS OF ADULT TERMINAL CANCER PATIENTS

Statement of the Problem

This study was designed to describe and analyze problems and coping patterns of a sample of adult terminal cancer patients in the Oncology Clinic at Grady Memorial Hospital, Atlanta, Georgia.

Purposes of the Study

1. To identify the problems experienced by the adult terminal cancer patients,

2. To identify and analyze the coping patterns of the patients,

3. To assess the patients' ratings of the effectiveness of the solutions.

Subjects, Methodology, and Instruments

The subjects were eighty terminal cancer patients, chronological ages eighteen and above, who received treatment at the Oncology Clinic of Grady Hospital. Thirty-two were males and forty-eight were females. Fifty were Black, twenty-nine were White, and one was Puerto Rican. Four types of

cancer were used, namely, breast, leukemia, lung, and upper gastro-intestinal tract. A stratified random sample was chosen consisting of eighty participants.

The instruments used were an Interview Schedule and a Background Information Card. This latter instrument provided information on the patient's age, sex, race, address, income, and marital status. The Interview Schedule was used to acquire information about problems patients encountered in their coping efforts.

Information was obtained on these eight types of coping behavior: (1) Patient's awareness of diagnosis, (2) Patient's financial problems, (3) Patient-doctor relationship, (4) Family attitudes toward patient and his/her diagnosis, (5) Patient's psychological problems, (6) Treatment procedure, (7) Patient's living arrangements, (8) Patient's leisure-time activities.

The treatment of the data was focused on interpreting data relating to the problems, solutions, and ratings of effectiveness of solutions. Responses to the open-ended and short-answer items were grouped under categories. Frequencies, distributions, and percentages were obtained for these items.

Major Conclusions

The patients in each of the four cancer areas seemed to encounter different problems; however, all the patients encountered psychological problems due to their diagnoses.

The patients in the four cancer areas differed in their attempts to solve problems created by their illnesses. Leukemia patients seemed to have made better overall attempts to develop solutions to their problems than patients in the other cancer areas.

As a whole, patients in the four cancer areas tended to rate the solutions to their problems as not effective or making the problem worse.

Recommendations for Future Research

1. A comparative study of patients at a private hospital such as Crawford Long Hospital, to determine if socio-economic status has influences on coping patterns of the patients. Do cancer patients in a private hospital have the same problems as cancer patients in a teaching hospital? Does the medical staff relate to cancer patients in both settings in similar ways?

2. A comparative study of male and female cancer patients to determine if they use similar methods in coping with cancer.

3. An investigation of the religion of each cancer patient to see if religion affects coping patterns.

4. A comparative study of White and Black cancer patients to determine if race has an effect on the coping methods employed.

5. A replication of this study using large number

of cancer patients from other hospitals in Atlanta or the Southeast to improve the generalizability of the findings.

6. An investigation of patients' attitudes toward death to see if this affects their coping patterns.

AN ANALYSIS OF COPING PATTERNS OF ADULT TERMINAL CANCER PATIENTS

A DISSERTATION

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Elizabeth City, North Carolina M.M.A.

IN MEMORY OF A DEAR FRIEND

THELMA DARYL BROWN

1951 - 1979

CHAPTER I

INTRODUCTION

Cancer is the most feared and dreaded of all diseases. It attacks people of all ages, races, and socioeconomic statuses. It spreads by means of uncontrolled growth of abnormal cells. In the United States, cancer is a leading cause of death, second only to heart disease. More than 800,000 Americans receive medical care for cancer each year and about 290,000 die from the disease. Cancer kills more children than any other disease. About 5,000 children, under the age of 15 years, die of cancer each year, and half of these deaths result from leukemia, a cancer of the blood-forming tissues.[1]

McIntosh stated that the fear of cancer is well founded. About one person in five dies from a malignant condition; and, from the ages of 45 to 64, one-third of all deaths are due to cancer. A considerable proportion of cancer sufferers, approximately one-third, is treated successfully and cured. Success is measured by means of survival

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[1]Kenneth M. Endicott, "How Cancer Is Treated," World Book Encyclopedia (Chicago: Field Enterprises Educational Corporation, 1968), III, 135-136.

after treatment rather than in terms of absolute cure.[2]

According to Worby and Babineau, cancer represents a crisis situation in the lives of patients and their significant family members. Even though the crisis offers dangers in the face of death, it also offers opportunity to do something about life. Although patients whose cancers have been detected and diagnosed may live years longer, due to medical progress, their lives are never the same. They must continue to live, and life will be made more bearable if they, and their family members, can participate in the diagnosis, treatment, and general care of the diseases. Patients and their family members must also be helped to verbalize suppressed feelings as a step toward adjusting to the dangers of cancer.[3]

Cancer is a complex chronic disease which has an impact upon the patients. Family members may help them by providing encouragement and moral and financial support. Professional health care is provided for the patients by doctors, nurses, counselors, and other health care personnel. The responsibility of living with cancer and its pain rests entirely on the patients who must devise some means or strategies of coping.

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[2]Jim McIntosh, "Process of Communication, Information Seeking and Control Associated with Cancer: A Selective Review of the Literature," Social Science and Medicine, 8 (April, 1974), 167.

[3]Cyril M. Worby and Raymond Babineau, "The Family Interview: Helping Patient and Family Cope with Metastatic Disease," Geriatrics, 20 (June, 1974), 90-93, 94.

The need to cope is a universal problem. Every person has personality characteristics which help to determine his/her coping behavior. Some people have greater repertoires of coping strategies than others. No type of coping behavior can be fully understood without knowing the problem or the context in which that problem is activated. Coping has connotations similar to the concept of defense mechanisms; but it includes a broader range of actions persons can use to help vitiate the impact of stress. Coping includes processes, such as individual flexibility, habits of information-gathering, and a variety of defense mechanisms.

It has been difficult defining coping more precisely, because it has been held that almost any response, by persons to stress, is coping behavior. A more specific definition of coping is possible if one analyzes behavioral responses in terms of short and long-term consequences, and, also, in terms of internal versus external changes. Truly functional coping behavior lessens the immediate impact of stress and allows persons to maintain a sense of self-worth and unity with their past and anticipated future.[4]

In an indigent patient population, staff members sometimes become overprotective and paternalistic, thereby not allowing the patients to fully express themselves. Too often decisions are made on the basis of the staff's individual

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[4]Harold V. Sotsky, David Hamburg, Marion Goss et al., "Coping Behavior Under Extreme Stress," Archives of General Psychiatry, 5 (1961), 423-448.

projections and values without any reliable corrective input from the patients.

This study, therefore, is important because its main focus is on what the patients view as their problems and the coping behaviors that are displayed by them. In order for the medical staff and other personnel to be supportive, they must give consideration to what the patients see as their primary needs or problems.

Statement of the Problem

This study described and analyzed problems and coping patterns of selected adult terminal cancer patients in the Oncology Clinic at Grady Memorial Hospital, Atlanta, Georgia.

Purposes of the Study

More specifically, the purposes of the study were:

1. to identify the problems experienced by the adult terminal cancer patients,
2. to identify and analyze the coping patterns of the patients,
3. to assess the patients' ratings of the effectiveness of the solutions.

Basic Assumptions

This study was based on the assumptions presented below:

It was assumed that the adult cancer patients, from the Oncology Clinic, have major problems in dealing with their

illnesses and other related factors. Based on the researcher's observations, patients complained and appeared dissatisfied while attending the Oncology Outpatient Clinic.

It was assumed that the staff of the Oncology Clinic had not properly identified those problems experienced by patients; and, therefore, could not offer much assistance to these patients. It was also assumed that the staff of the Oncology Clinic could improve its identification of the patients' problems. It was further assumed that the staff's assistance to these patients could be significantly improved.

It was also assumed that the treatments the patients were receiving for their illnesses (radiation, chemotherapy, etc.) would not interfere with patients' responses during the interview. Patients who were under the influence of adverse treatment procedures would be identified by the research nurses and interviews would not be conducted at times when treatment would affect their typical response patterns.

It was further assumed that the researcher's interview skills, training, and experiences as a medical social worker would not produce the experimenter bias effect that could contaminate the results of the study.

It was further assumed that these patients had some coping patterns for dealing with their problems.

The final assumption was that the Interview Schedule and Background Information Card could and would be effectively used in gathering the necessary information from the patients.

Limitations

Some limitations of this study were those listed below:

1. The accuracy of the findings could be influenced by the accuracy of the participant's perceptions of the severity of problems and the effectiveness of their solutions.

2. Generalizations of findings should be restricted to those that can be made from evidence produced by the population from which the sample was drawn.

3. The Interview Schedule may be used with various levels of effectiveness. Also its validity has not been determined, thus, the validity of the information produced is questionable. There is also a chance that the respondents, producing the information in the Background Information Card, may respond to the items therein differently from the intentions of the preparer of the Background Information Card.

Interviewer bias is a weakness of the interview approach. The interviewer can project his/her own personality into the situation and thus influence, by means of intonation, gestures, and facial expressions, the responses he/she receives. Attempts to control these biases were made by the interviewer developing effective techniques which gave direction and focus to the interview but avoided domination and control of the client's responses. The way questions were asked and the language employed by the interviewer were elements that led to effective interviewing techniques.

Definitions

For the purposes of the study, the following terms were defined to have the meanings listed below:

Adult Cancer Patient--A person who was 18 years old or over and had been identified by the physicians at the Oncology Clinic of Grady Memorial Hospital as having terminal cancer.

Cancer--A group of diseases in which there was an uncontrolled and disordered growth of abnormal cells. Patients in this study were identified by the physicians at Grady Hospital's Oncology Clinic as having terminal cancer of the breast, lung, blood (leukemia), and gastrointestinal tract.

Coping Patterns--Characteristic ways in which patients in the study responded to the pain, fear, anger, and loneliness associated with having cancer, and to other problems created by treatment procedures, family members, and hospital personnel. An adult terminal cancer victim may cope with his cancer by going to church more often, seeking more information and assistance or belonging to organizations composed of individuals with similar illnesses. Coping patterns may be seen as defense mechanisms or ways of dealing with threats brought about by the disease of cancer.

Oncology--The study of cancer.

Oncology Clinic--The outpatient facility of Grady Memorial Hospital that was responsible for the diagnosis and treatment of patients with cancer. The Grady Memorial Hospital's Oncology Clinic was under the directorship of a doctor (Chief Oncologist) and many physicians, nurses, social workers, and chaplains work there. The Oncology Clinic utilized the team approach in helping patients with cancer.

Problems of Cancer--The patients in this study were concerned with many problems, including:

(a) personal fear of death, pain, and confinement;
(b) anger, guilt, anxiety, and embarrassment;
(c) problems created by their own family members' awareness of diagnosis; and
(d) problems created by the treatment procedures, medical personnel, living arrangements, and depleting finances.

Terminal Cancer--The final stage in the development of cancer in which death was likely to occur. "A basically uncontrolled progressive disease in which the cancer has become metastatic. In distinction to some fatal illnesses, however, death frequently is delayed several months or even years after the diagnosis is established

and treatment must be aimed at palliation and management of the dying phase."[5]

The Setting

Grady Memorial Hospital was the largest general hospital in Georgia. It was among the largest in the nation. The present building was first occupied during January 1958. It was twenty-one stories high and contained 27.6 acres of floor space. The hospital had eighteen operating rooms, five departmentalized emergency rooms (medicine, surgery, pediatrics, psychiatry, and obstetrics), nine delivery rooms, and an emergency X-Ray division. It had a maximum bed capacity of 1069, plus 325 bassinets.

The hospital was maintained principally to provide medical care for the indigent and sick, and for emergencies from Fulton and DeKalb Counties. The responsibility for governing the hospital rested with the Fulton-DeKalb Hospital Authority. Medical care at Grady was provided under contract with the Emory University School of Medicine; and, in addition to Intern and Residency Programs, the hospital operated schools for the training of graduate nurses, radiological technologists and medical technologists. Additionally, the Department of Pharmacy conducted an Intern Program for pharmacists. Affiliations were maintained with the University

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[5]Albert Rothenberg, "Psychological Problems in Terminal Cancer Management," Cancer, 14 (September-October, 1961), 1063-1073.

of Georgia and Atlanta University for the training of social workers.

To be eligible for the services of Grady Hospital, persons must live in Fulton or DeKalb Counties with the intent of residing there permanently. The Director of the Admitting Department was authorized to require satisfactory proof of residence of any patient being classified. Financial eligibility was based on a sliding scale of gross income.[6]

The Oncology Clinic

The Oncology Clinic was a new centralized cancer unit at Grady Memorial Hospital. It opened in July 1974, and provided oncological and medical care for approximately three hundred cancer patients. The Clinic also provided oncological consultations for outpatients of other services, conducted clinical research, and taught the basic principles of medical management of cancer patients to medical students, interns, physicians' assistants, and student nurses. The Clinic exposed student nurses to outpatient oncology nursing and clinical research.[7]

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[6]The Fulton-DeKalb Hospital Authority, Grady Memorial Policies and Procedures Manual (July, 1977-78), p. 1.

[7]Grady Memorial Hospital, "Principles of Practice for the Medical Oncology Clinic," A Memo Distributed to the Staff of the Oncology Clinic (July, 1974), p. 2.

CHAPTER II

REVIEW OF THE LITERATURE

Cancer is a disease that is feared by mankind. Its causes are unknown and its courses unpredictable. Cancer is also unique because the first warning signs seem so trivial.

Hoffman notes that the history of cancer can be traced backwards by an unbroken record to early Greece and even to ancient India and Egypt. Hippocrates was acquainted with cancer of the breast and he recognized the occurrence of malignant disease in certain of the internal organs as well. Cancer was well known to Galen, one of the ancient founders of medicine. Surgical operations, on account of cancer, were practiced by Leonidis (about 180 B.C.). He was the first to appreciate the importance of the retraction of the nipple as a diagnostic sign in cancer of the breast.[8]

The problems that arise from cancer, and from the fear of cancer, are among the most difficult that a doctor, patient, or the family of a cancer patient is called upon to face.

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[8]Frederick L. Hoffman, The Mortality from Cancer Throughout the World (Newark, New Jersey: Prudential Press, 1916), p. 2.

In the review of literature, the investigator examined the various definitions of "coping."

Definitions of Coping

Authorities have offered numerous definitions of "coping." Each has been different, yet none has been so different that a vestige of similarity cannot be detected.

Weisman posits that in every coping situation a specific problem must be identified. In his opinion, coping is a problem-solving process which, if effective, brings relief, reward, quiescence, and equilibrium. Like motivated behavior, in general, coping consists of active measures to master and avoid or minimize specific threats.[9]

Perlman supports Weisman's position that coping is a problem-solving process. Its purpose is mastery or problem-solving at best; at the least, it serves to reduce tension and ameliorate the problem.[10]

According to Dimsdale, coping has connotations similar to the concept of defense mechanisms. But it includes a broader range of actions the person can use to help vitiate the impact of stress. Coping includes processes such as individual flexibility and habits, information-gathering,

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[9]Avery D. Weisman, "Coping Behavior and Suicide in Cancer," in Cancer: The Behavioral Dimensions, DHEW Publication No. (NIH) 76-1074; 3-9.

[10]Helen H. Perlman, "In Quest of Coping," Social Casework, 56 (April, 1976), 213.

as well as a variety of defense mechanisms.[11]

The other areas discussed in the review of the literature are:

1. patient-doctor relationships,
2. treatment procedures,
3. stigmas,
4. emotional reactions,
5. effects of terminal cancer upon the patient's household,
6. problem-solving or coping techniques used by the patient and his/her family.

Patient-Doctor Relationships

Patient-doctor relationships constitute major sources of problems for both patients and doctors.

Krant noted that some physicians have little trouble when a patient acts as he "should," which is not to ask too many questions, but to smile and comply with the doctor's wishes. Trouble occurs when a patient acts differently. Physicians, in general, feel threatened by such behavior, because they do not know how to respond, and, therefore, feel attacked. Most physicians receive little training in understanding coping styles and coping mechanisms.[12]

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[11]Joel E. Dimsdale, "The Coping Behavior of Nazi Concentration Camp Survivors," American Journal of Psychiatry, 3 (July, 1974), 792-797.

[12]Melvin J. Krant, "Problems of the Physicians in Facing the Patient with the Diagnosis," in Cancer: The Behavioral Dimensions, DHEW Publication No. (NIH) 76-1074; 3-9.

This conclusion is supported by a study conducted by Artiss and Levine. In this study, a practical teaching seminar that used the principles of preventive and social psychiatry was organized.

Six to ten oncology physicians met weekly with a psychiatrist and a senior attending physician for approximately five months. Findings revealed that the major initial defenses of the oncology physicians were identified as anger and denial. The most severe problems discussed were the formation of dependency relations between doctors and patients, the patients' denials of illness, the phenomenon of social death, and the physician's identification with his patient. Generally, the oncology physicians participating in the seminar were not prepared for the very important degree of patients' reactions to the dangers of death that they encountered. They were unprepared in expectancy and the skills of working with psychological aberrations. Some physicians often concealed their embarrassment and dismay under cloaks of withdrawal, lack of interest, and ridicule.[13]

Hayes observed that if a physician expresses too much anxiety because of working with cancer patients, he will not be able to assess and observe the patients' emotional reactions to the disease. In such instances, physicians tend to

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[13]Kenneth L. Artiss and Arthur S. Levine, "Doctor-Patient Relation in Severe Illness," New England Journal of Medicine, 288 (June, 1973), 1210-1214.

defend themselves by involuntary aloofness from patients or by rigid stereotyped management of all patients with cancer. Sometimes anxiety within the physician leads him to circumlocution, omissions, and untruths when he is forced to talk to cancer patients.[14]

Golden and Johnston agreed with Hayes and offered the explanation that physicians too often fail to recognize that what they tell patients is sometimes not understood by the patients. The conditions which interfere with adequate understanding include the anxiety of the patient about what is being told to him, his intelligence, and opportunities to question his medical informant. Golden and Johnston made a study which investigated the patient's understanding of what was said to him by the physician. In the study, physicians were selected in a random fashion from several services of a general hospital. The experimenters tape-recorded interviews in which significant information was being communicated to a patient by the physicians selected. Examples were the presentation of results of a diagnostic work-up in a medical ward or the discussion with a pre-operative patient of the indications for and complications of an operation. Twenty-five patient interviews were recorded. The age range of the patients was from 20 to 70 years old. There were ten Blacks, fourteen Whites, and one Oriental patient. Seventeen

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[14]Donald M. Hayes, "The Impact of the Health-Care System on Physicain Attitudes and Behaviors," in Cancer: The Behavioral Dimensions, DHEW Publication No. (NIH) 76-1074; 1-169.

were females and eight were males. The patients were seen by twelve different physicians from four hospital services. The tape recordings were transcribed and analyzed for the presence of significant distortions by patients. Obvious misunderstandings or confusions about points of minor significance or no misunderstandings were found.[15]

Findings revealed that of the twenty-five patients, ten were categorized as showing significant distortions, four minimal distortions, and eleven no significant distortions. Findings also showed that when the physicians had rapport with their patients there was less distortion. Probably there was less anxiety and a greater tendency for the patient to ask clarifying questions or to reveal his ignorance without too much fear or embarrassment or a frightening answer. When there was inadequate rapport between doctor and patient, or when the doctor's explanations were cursory, confusing, or unresponsive to the subtle cues that frightened the patient, distortion appeared more frequently.[16]

Some major factors in the care of a patient are the physician's attitudes toward people, patients, diseases, and themselves. The wide variations in physicians' attitudes observed in clinical practice raise the following question:

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[15]Joshua S. Golden and George D. Johnston, "Problems of Distortion in Doctor-Patient Communications," Psychiatry in Medicine, 1 (April, 1970), 27-49.

[16]Ibid.

What are the roles of education, clinical experience, and basic personality in the attitude development of the individual physician? The clinical situation chosen for investigating this question was care of cancer patients.

In the study conducted by Haley, Juan, and Gagan, six hundred statements expressing attitudes related to care of cancer patients were extracted from:

1. tape recordings of group discussions by physicians on various cancer questions;
2. examinations of questionnaires given to second, third, and fourth-year medical students over a period of two years;
3. relevant literature;
4. experience and knowledge of investigators.

Five areas were selected as being of primary interest:

1. diagnosis,
2. treatment,
3. patient's inner resources,
4. doctor-patient relationships,
5. attitudes toward death.

A proposition expressing a particular orientation was framed for each of these areas:

1. early diagnosis leads to better care of the cancer patient,
2. aggressive treatment increases the cure rate and improves the quality of living of incurable patients,
3. patients have inner resources to cope with cancer and death,
4. the doctor-patient relationships do not depend on achieving cure,

5. everyone must accept and live with death.

From those statements expressing opinions, favorable or unfavorable, to these five propositions, 171 were selected, edited, and compiled into a questionnaire for distribution to approximately 350 persons. The 265 completed questionnaires provided a criterion group of 163 physicians, 89 medical students, and 13 laymen.

Findings by Haley, Juan, and Gagan revealed only three specific factors. Two of these clearly defined two of the attitude areas while the third was a combination of two others. The factor analysis also identified those items most representative of the areas isolated. Of the 64 items, 28 were included in the 3 scalable factors. They were ranked, in each factor, according to their contributions to it as a whole. Those items with the highest loadings provided the basis for interpretation. The other 37 items were grouped into 7 factors outside of the areas originally postulated. When doctor and student responses to individual items were compared to chi-square tests, statistically significant differences were found on 17 items distributed among 7 percent of the 10 factors.[17]

Treatment Procedures

Doctors treat cancer by means of surgery, radiation,

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[17]Harold B. Haley, Isabel R. Juan, and Jean F. Gagan, "Factor-Analytic Approach to Attitude Scale Construction," Journal of Medical Education, 43 (March, 1968), 311-361.

or chemotherapy. The choice of treatment depends on the type of cancer involved and the location of the growth in the body.[18]

Vettese noted that treatment procedures can present major problems for patients. The basic concerns for patients who undergo surgery are fear of:

1. the los of normal bodily functions,
2. body mutilation or amputation,
3. the extent the disease has invaded the body.

Radio-therapy machinery and chemotherapy equipment and protocols are often frightening because of their complexity and can be overwhelming to patients subject to them.[19]

Quint conducted a study of twenty-one women who entered a university medical center hospital for mastectomies. The women ranged in ages from 38 to 79 years. Their median age was 57. Six women were married, nine were widows, and six were single. Data collection began during the patients' hospitalization and continued with periodic home contacts at selected intervals during one year. In both settings, data were collected by a nurse and author using the method of participant observation. A tape recorder was used for home conversations, but observations in the hospital were dictated onto tape shortly after they were noted.

The findings revealed were:

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[18]Endicott, "How Cancer Is Treated," pp. 135-136.

[19]Joann Vettese, "Problems of the Patient Confronting the Diagnosis of Cancer," in Cancer: The Behavioral Dimensions, DHEW Publication No. (NIH) 76-1074, 1-169.

1. mastectomy precipitated a period of shock and unexpected events,

2. the patients were appalled by the changes in bodily appearances,

3. patients felt that a mastectomy would change their futures by the prospect of shortened life and the possibility of slow, painful death.[20]

In supporting the thesis that treatment procedures present problems for cancer patients, Peck and Boland did a study to detect patients' emotional reactions to radiation therapy treatments. During an eighteen-month period, 50 cancer patients were selected for study. The average age of the patients was 56 years. There were 13 males and 37 females.

All 50 subjects described themselves as working. The anatomical sites of cancer were: pelvis, 14; head and neck, 12; breast, 11; chest, 7; abdomen, 4; and reticulo-endothelial system, 2. The patients were interviewed by a psychiatrist before the course of radiation commenced, but after the initial assessment by a radio-therapist. A second interview was conducted by the same psychiatrist within one week of the completion of radio-therapy. During a course of treatment, each patient was seen at least once per week by a radio-therapist and more frequently, if necessary. Interviews lasted 45 to 90 minutes. They were structured, but subjects were allowed to volunteer statements and ask questions.

Findings by Peck and Boland revealed that interviewees,

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[20]Jeanne C. Quint, "The Impact of Mastectomy," American Journal of Nursing, 63 (November, 1963), 88-92.

after completing treatment, showed incidences of depression and anxiety that were greater than in the pre-treatment interviews. This indicated that radiation therapy is stressful in itself.[21]

Stigmas

Most persons in today's society share feelings, to a greater or lesser degree, of the stigma of having cancer. Goffman uses the term "stigma" to refer to an attribute that is extremely discrediting. According to Goffman, the Greeks, who were apparently strong on visual aids, originated the term "stigma" to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier.[22]

Numerous authorities have pointed to the fear of cancer among professionals as a stumbling block to service delivery for cancer patients.

In a study conducted by Pinkerton and McAleer, 34 practicing counselors were asked to complete a series of tasks related to counseling and service delivery with the cancer patient. The results strongly support general conclusions in the literature that counselors are likely to

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[21]Arthur Peck and John Boland, "Emotional Reactions to Radiation Therapy," Cancer: A Journal of the American Cancer Society, 40 (July, 1977), 180-184.

[22]Erving Goffman, Stigma (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963), pp. 1-3.

provide less counseling and case services to cancer patients than to patients with other equally devastating disease-related disabilities. A relationship is demonstrated between case service, attitudes toward the cancer patient, and personal fear of cancer.[23]

Rothenberg points out that the word "cancer" or "crab" captures what is probably the popular psychological conception of this disease, a faceless, crawling process, slowly clawing at and devouring one's insides. There is also a strong feeling that cancer is contagious.[24]

A study supporting this view was conducted by Horn and Waingrow. In June and July of 1948, the Survey Research Center of the University of Michigan conducted a national sample survey for the American Cancer Society. The survey covered many aspects of public reactions to cancer. Information was collected by personal interviews with 1,244 persons, selected by random procedure, to represent the adult population living in private households in the United States.

Findings by Horn and Waingrow revealed that feelings of aversion to cancer, and cancer patients, appeared to stem from the belief that cancer is contagious; and, therefore, contact with a cancer patient was dangerous. Responses in the three survey years to the question, "Do people catch

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[23]Susan S. Pinkerton and Charles McAleer, "Influence of Client Diagnosis-Cancer on Cancer Counselor Decision," Journal of Counseling Psychology, 23 (1976), 575-578.

[24]Rothenberg, "Psychological Problems," pp. 1063-1073.

cancer from one another?" revealed these results: the percentage which said "yes" in answer to this question dropped from 10 percent to 6 percent in the first two surveys and stayed at 6 percent in the third. Another question was, "Would you be willing to work next to someone who has cancer?" The percentage answering "no" dropped from 29 percent to 13 percent in the first two surveys, but barely changed to 12 percent in the third.[25]

Emotional Reactions

Holland observed that for most people the word "cancer" alone produces fear. The fears are several:

1. threat of death with loss of self and others,
2. uncertainty of the future,
3. fear of pain,
4. fear of loss of body parts or function,
5. fear of loss of social role,
6. fear of enforced dependency,
7. fear of alienation from others.[26]

Peck did a study to determine patients' emotional reactions to having cancer. Between June 1968 and October 1969, 50 cancer patients, starting radiation therapy at the Mount

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[25]Daniel Horn and Selwyn Waingrow, "What Changes Are Occurring in Public Opinion Toward Cancer: National Public Opinion Survey," American Journal of Public Health, 54 (March, 1964), 431-440.

[26]Jimmie C. Holland, "Coping with Cancer: A Challenge to the Behavioral Sciences," in Cancer: The Behavioral Dimensions, DHEW Publication No. (NIH) 76-1074, 3-19.

Sinai Hospital of New York, were evaluated by a psychiatric interview. Interviews lasted 45 to 90 minutes. The age range was 14 to 80. There were 23 males and 27 females, 39 Whites and 11 Blacks. Each patient was interviewed by a psychiatrist. A chronological account of the current illness was sought, stressing the patient's initial observations and reactions, medical contacts and procedures and reactions to them, and expectations of the future course of the illness by developing a psychiatric disorder. Twenty-two patients had severe anxieties, nineteen moderate anxieties, and eight mild anxieties.[27]

The results of a study by Abrams and Finesinger supported the thesis that cancer produces fear in patients. The material forming the basis of the study was gathered by the psychiatrist and social worker in numerous interviews. An unselected series of 60 patients with cancer of various parts of the body comprised the study group. There were 44 females and 16 males. Findings showed that a verbatim account of data collected regarding patients' attitudes toward their disease revealed fear to be the most obvious reaction.[28]

Weisman sums up this view when he points out that the diagnosis of cancer terrorizes people, evoking the image of

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[27]Arthur Peck, "Emotional Reaction to Having Cancer," American Journal of Roentgenology Radium Therapy and Nuclear Medicine, 114 (March, 1972), 591-599.

[28]Ruth D. Abrams and Jacob E. Finesinger, "Guilt Reactions in Patients with Cancer," Cancer, 6 (May, 1953), 474-482.

invalidism, incapacity, and death, regardless of the actual prognosis and available treatment.[29]

A study by Craig and Abeloff supports this view. In this study, the population consisted of 30 patients admitted consecutively to the Oncology Research Unit at the Baltimore City Hospitals, Baltimore, Maryland, during the period of March 1972 through May 1972. Within 49 hours after admission each patient was asked to complete a copy of the SCL-90. The SCL-90 is a self-report symptom inventory that consists of a self-administered 90-item instrument. The inventory assesses the degree to which the respondent was distressed by each item during the past week. The items were then clustered into scores in nine underlying symptom dimensions:

1. somatization,
2. obsessive-compulsiveness,
3. interpersonal sensitivity,
4. depression,
5. anxiety,
6. hostility,
7. phobic anxiety,
8. paranoid ideation,
9. psychoticism.

Each item of the SCL-90 is rated by the respondent on a scale from 0 to 4. Scores from the nine subjects are then computed so that the composite subject score has a potential range of

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[29]Weisman, "Coping Behavior and Suicide," pp. 3-9.

0 to 4. Findings revealed that more than half of the patients showed moderate to high levels of depression and 30 percent had elevated levels of anxiety. Nearly one-fourth had overall symptom patterns virtually identical to those seen in patients admitted to an emergency psychiatric service.[30]

Effects of Terminal Cancer Upon the Patient's Household

The patient's illness definitely has numerous effects on the family members. Vettese observes that the family, similar to the patient, is often traumatized by the diagnosis of cancer. It plays a significant role during the time of illness, and its reactions will contribute a lot of the patient's response to his illnesses.[31]

Terminal cancer is known to have effects on husband-wife relationships. Frequently, the cancer patient and his/her spouse have problems regarding sexual intercourse.

Dyk and Sutherland observe that a number of cancer patients who had radical mastectomies expressed fears of injuring the operative site.[32]

In support of the views mentioned, Leiber, Plumb,

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[30]Thomas J. Craig and Martin D. Abeloff, "Psychiatric Symptomatology Among Hospitalized Cancer Patients," American Journal of Psychiatry, 131 (December, 1974), 1323-1327.

[31]Vettese, "Problems of the Patient," pp. 3-19.

[32]Ruth B. Dyk and Arthur Sutherland, "Adaptation of the Spouse and Other Family Members to the Colostomy Patient," in The Psychological Impact of Cancer (New York: American Cancer Society, 1974), pp. 74-87.

Gerstenzung, and Holland conducted a study regarding communication of affection between cancer patients and their spouses. Thirty-eight patients receiving chemotherapy for advanced cancer and 37 of their spouses were studied to assess changes since illness in the desire for affection (sexual, physical, and verbal) and changes in actual affectional behavior. Each participant in the study was interviewed and then completed the Beck Depression Inventory and Affectional Needs, customary modes of expressing those needs, change in affectional needs and behaviors subsequent to the onset of cancer, and major areas of concern. The findings of Leiber et al. revealed the following:

1. For patients and spouses of both sexes, desire for sexual intercourse decreased and desire for nonsexual physical closeness increased subsequent to illness onset. There was a trend for sexual desire to decrease as depression increased, but no relationship was found between changes in desire for physical closeness and level of acknowledged depression. The patient's physical status bore little relationship to either of these changes except the men patients, of poor physical status, tended to report less sexual desire than men patients whose physical condition was less impaired.

2. The Beck Depression Inventory Scores indicated that women patients were the most depressed while their husbands were the least depressed of the four groups.

3. The correspondence between changes in desire and changes in actual affectional behavior was greater for patients than for spouses and greater for women patients than for men patients. Thus, women patients, although significantly more depressed than the other three sub-groups, were most likely to have their affectional needs met, while their husbands were least likely.

4. Men patients and their wives tended to be in less agreement with regard to affectional needs, affectional behaviors, and major concerns than were women patients and their husbands.[33]

The results of this study appear to suggest that special attention should be paid to the psychological status of:

1. husbands of cancer patients because their needs are poorly met and perhaps infrequently expressed, and

2. to men patients and their wives who may experience increased intramarital tension as a consequence of their disparate needs and altered sex roles.[34]

Problem-Solving or Coping Techniques

Although cancer imposes particular stresses, individuals have their own susceptibilities and they have preestablished tendencies to cope in their own special patterns. Weisman, in his study of coping behavior and suicide in cancer patients, identifies fifteen different coping strategies used by these patients. These common coping strategies are as follows:

1. seeking more information,

2. talk with others to relieve distress,

3. laugh it off,

4. don't worry, try to forget,

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[33]Lillian Leiber, Marjorie M. Plumb, Martin L. Gerstenzung, and Jimmie Holland, "The Communication of Affection Between Cancer Patients and Their Spouses," Psychosomatic Medicine, 38 (November-December, 1976), 178-389.

[34]Ibid.

5. put mind on other things,
6. positive, constructive action based on present understanding,
7. accept but rise above it, find something favorable,
8. stoic acceptance of the inevitable,
9. do something, anything, however reckless, impractical, etc.,
10. do what worked in other situations,
11. get away by yourself,
12. reduce tension by drinking, drugs, etc.,
13. blame someone or something for your condition,
14. seek direction and do what you are told,
15. blame yourself, atone, sacrifice.[35]

A study was conducted by Sanders and Kardinal to detect the coping mechanisms used by adult leukemia patients. Six patients, four men and two women, ranging in ages from 24 to 62 years and being treated with monthly maintenance chemotherapy, were interviewed over a six-month period of time. The interview was designed to determine (1) how the patient perceived or experienced his/her present condition, (2) how he/she perceived his/her present life-style and changes related to the illness, (3) what specific coping patterns he/she had used in the past, and (4) what his/her expectations were for the future.

The assessment interviews were administered over a six-month period, usually at one-month intervals, to determine patterns in coping behavior. Findings revealed that

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[35]Weisman, "Coping Behavior and Suicide," pp. 3-9.

the coping mechanisms most frequently identified were denial of being sick, identification with fellow patients to form a "hospital family," and anticipatory grief of one's own losses by participation in grieving another patient's death. The means of adjustment were to adapt to the "hospital family" and benefit from the therapeutic milieu established on the ward.[36]

Another problem-solving technique employed by terminal cancer patients is seeking extensive information about their disease. Klagsburn described a librarian who, upon learning that she had cervical cancer, went through recent medical journals reading about her illness, survival statistics, and preferred treatment procedures. She needed a sense of control over her own destiny.[37]

A study that supports this view was conducted by Lanzetta and Driscoll. The purpose of this was to determine the preference for information about an uncertain but unavoidable outcome.

Subjects were 24 male undergraduates. They were recruited, individually, from freshman physical education classes at the University of Delaware. Subjects sat before a table containing a poker chip delivery mechanism, a response

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[36]Judith B. Sanders and Carl G. Kardinal, "Adaptive Coping Mechanisms in Adult Acute Leukemia Patients in Remission," Journal of the American Medical Association, 238 (August, 1977), 952-954.

[37]Samuel C. Klagsburn, "Communications in the Treatment of Cancer," American Journal of Nursing, 71 (1971), 944-948.

box, and a signal panel. The subjects were instructed that the experimenter was interested in studying how individuals respond to pleasant and unpleasant outcomes. The subjects were told what outcomes were possible in the first situation and the experimenter stressed that each outcome would occur equally often on a random basis which was being partially controlled by a randomizing machine. The subjects could discover which outcome was to occur by pushing a button labeled "information." If the subject depressed the "no information" button, there was a ten-second period before the outcome occurred. Each subject was given 90 trials on which he had the choice of acquiring or not acquiring information about which of two equally likely outcomes would occur. The occurrence of the signal lights and the subject's choice of information were recorded by an Esterline-Angus events recorder. Programming and recording equipment was in an observation room separated from the experimental room by a one-way mirror.

Findings of this study showed that humans preferred information about an uncertain outcome even when they were unable to modify overtly the outcome. Uncertainty-induced conflict motivated information acquisition even when the information has no apparent instrumental value.[38]

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[38]John T. Lanzetta and James M. Driscoll, "Preference for Information About an Uncertain but Unavoidable Outcome," Journal of Personality and Social Psychology, 3 (January, 1966), 96-102.

It is also evident that family members of terminal cancer patients employ problem-solving techniques or coping patterns in regard to cancer. Lepper investigated the problems and coping patterns of thirty-nine family members who had the major responsibility for home care of the adult female patient with cancer. An interview was held with each family member in order to (1) describe problems and solutions of the responsible family member; (2) assess, by means of ratings, the severity of the problems and the effectiveness of the solutions used; and (3) identify family members' coping patterns.[39]

The problems experienced by the household members caring for adult female cancer patients at home included the aura of secrecy surrounding the diagnosis and making it impossible to discuss the problems in the patient's presence. The responsible family members were employed, and, therefore, not at home during the nurse's visit to the house. The quality and quantity of the family members' care of the patient were limited by negative reactions to the diagnosis: (1) they sought professional advice, treatment, or reassurance in coping with problems of odor and/or drainage, irrigation, and/or dressing procedures, housekeeping, and/or shopping, sleeping arrangements, and/or habits and finances;

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[39]Kathleen E. Lepper, "Problems and Coping Patterns of the Household Member Caring for the Adult Female Cancer Patient in the Home," (Ed.D. dissertation, Columbia University, 1968), 88-89.

(2) they sought advice or assistance from relatives in coping with problems of leisure-time activities; and (3) they took action, self-directed, in coping with problems of awareness or lack of awareness of the diagnosis and living arrangements.[40]

Another related study was conducted by Bozeman, Orbach, and Sutherland. This investigation was conducted to determine the adaptations of mothers to threatened losses of their children from acute leukemia. Twenty mothers of 11 boys and 9 girls, who ranged in ages from one and a half to six and a half years, were included in the sample. Intensively focused interviews and the Thematic Apperception Test were the procedures employed in assessing their adaptations. Initial interviews with all mothers occurred while their children were undergoing treatment at the Memorial Center for Cancer and Allied Diseases. Findings revealed that all the mothers initially attempted to deny the implications of the diagnosis by screening out the hopelessness of the prognosis or by frantic attempts to disprove the accuracy of the diagnosis through consultations with other physicians. Many mothers expressed guilt and assumed personal responsibility for their children's illnesses. The mothers also utilized existing relationships or developed new ones to deal with their most acute needs. The dependency expressed in these supportive relationships constituted

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[40]Ibid.

a constructive effort to increase mastery in coping with such a massive threat.[41]

Moos and Tsu noted that terminal cancer patients, in their efforts to cope, employed a belief in a divine purpose or in the general beneficence of a divine spirit which served as consolation or as encouragement to do one's best to deal with the difficulties one encounters.[42]

This view was examined in a study conducted by Carey. A quantitative approach was used to identify factors relating to emotional adjustment in 84 terminal patients. Eleven hospital chaplains collected data by interviewing terminally ill patients. In this project, a terminally ill person was defined as one whose illness was such that death was probable within a year. Half of the patients were male and the other half female. They ranged in chronological age from 13 to 82 years. Fifty-six (66%) of the patients were married, fourteen (17%) of the patients were widowed, ten (12%) were single, and four (5%) were divorced. Eleven chaplains, 9 Protestants and 2 Catholics were involved in the program over the period of eight months. The data was recorded by the chaplains on a three-page data form and on a six-page patient questionnaire.

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[41]Mary F. Bozeman, Charles E. Orbach, and Arthur M. Sutherland, "Psychological Impact of Cancer and Its Treatment," Cancer, 1 (January-February, 1955), 1-18.

[42]Rudolph H. Moos and Vivien D. Tsu, "The Crisis of Physical Illness: An Overview," in Coping with Physical Illness, ed. by Rudolf H. Moos (New York: Plenum Medical Book Co., 1977), pp. 12-15.

Findings revealed that emotional adjustment to the awareness of a limited life expectancy was not related principally to religious orientation, although this was an important factor. Emotional adjustment was influenced more by the patient's physical condition (level of discomfort), by previous experiences with dying persons, and by interpersonal relationships, especially with the nearest of kin. Findings further suggest that:

1. the most important aspect of the religious variable was the quality of religious orientation, rather than mere religious affiliation of verbal acceptance of religious beliefs;

2. talking frankly about death and dying may not only help the patient sort out his own feelings but also assist the other person to adjust emotionally if he in turn contracts an incurable illness;

3. for religious persons, integrating religious beliefs into one's lifestyle may reduce the possibility of guilt and concern about God's loving care, and sustain a well-founded hope in a type of happiness after death, in the event of terminal illness; and

4. deep and loving relationships with family and friends will provide a solid support in the face of death.[43]

Summary

A summary of the significant items inherent in the literature reviewed herein reveals these points.

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[43]Raymond G. Carey, "Emotional Adjustment in Terminal Patients: A Quantitative Approach," Journal of Counseling Psychology, 21 (September, 1974), 433-439.

Coping is a problem-solving process. Its purpose is mastery of problem-solving. It serves to reduce tension and ameliorate the problem.[44]

Terminal cancer patients experience problems in relationship with their physicians. Cancer is a disease that provokes anxiety in patients and doctors alike. If a physician expresses too much anxiety, because of working with cancer patients, he will not be able to assess and observe the patients' emotional reactions to the disease. In such instances, physicians tend to defend themselves by involuntary aloofness from patients or by rigid stereotyped management of all patients with cancer.[45]

Treatment methods pose problems for cancer patients. Cancer is often treated with chemotherapy, radiation therapy, and surgery. Patients receiving chemotherapeutic treatment often complain of nausea, vomiting, and dizziness. The basic concerns for patients who undergo surgery are fear of loss of normal bodily functions, body mutilation, and amputation. Radiation therapy machinery are often frightening because of their complexity and can be overwhelming to patients who are subjected to them.[46]

Cancer patients are stigmatized by society. The word "cancer" or "crab" captures what is probably the popular

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[44]Helen H. Perlman, "In Quest of Coping," p. 213.

[45]Hayes, "The Impact of the Health Care System," pp. 1-169.

[46]Vettese, "Problems of the Patient," pp. 1-169.

psychological conception of this disease, a faceless, crawling process, slowly clawing at and devouring one's insides. Society has a strong feeling that cancer is contagious.[47]

Cancer patients have many emotional reactions regarding their illnesses. The most common reactions are:

1. threat of death,
2. uncertainty of the future,
3. fear of pain,
4. fear of loss of body part or function,
5. fear of loss of social role,
6. fear of enforced dependency,
7. fear of alienation from others.[48]

Cancer produces problems for the patients' households. The patient's family is often traumatized by the diagnosis of cancer. It plays a significant role during the time of illness, and its reactions will constitute a lot of the patient's response to his/her illness.[49]

Cancer patients have coping techniques for dealing with their disease. Weisman, in his study of coping behavior and suicide in cancer patients, identified several coping strategies used by these patients. The most common coping strategies included:

1. seeking more information about the illness,

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[47]Rothenberg, "Psychological Problems," p. 1069.

[48]Holland, "Coping with Cancer," pp. 3-19.

[49]Vettese, "Problems of the Patient," pp. 3-19.

2. talking with others to relieve distress,

3. putting the mind on other things,

4. blaming oneself, someone, or something for the condition,

5. reducing tension by drinking, or by using drugs,

6. positive, constructive action, based on present understanding,

7. stoic acceptance of the inevitable and resigning oneself to it.

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[50]Weisman, "Coping Behavior and Suicide," pp. 3-9.

CHAPTER III

RESEARCH DESIGN AND METHOD OF PROCEDURE

The procedures used to gather and analyze data for the study are described in this chapter. The data-collecting instruments, study sample, feasibility study, and method for analysis of data are described. The purposes of the study were:

1. to identify the problems experienced by the adult terminal cancer patients,
2. to identify and analyze the coping patterns of the patients,
3. to assess the patients' ratings of the effectiveness of the solutions.

Subjects

The subjects were 80 terminal cancer patients, ages 18 and above, who received treatments at the Oncology Clinic of Grady Memorial Hospital. There were 32 males and 48 females. Fifty Blacks, twenty-nine Whites, and one Puerto Rican were included in the study.

The Sample

Criteria of eligibility

The original plan was to include all adult patients in

the Oncology Clinic who had terminal cancer. This method had to be modified because some patients did not meet the criteria. In order to meet the criteria of eligibility, patients should have terminal cancer, be coherent and not in serious pain, and they should also be 18 years old or older. It was necessary to exclude patients who exhibited evidence of disorientation, severe memory loss, delusional thinking, or severe physical pain. The patients who exhibited evidence of these problems were not eligible to participate in the study. However, this decision was made for the following reasons.

1. It was considered inappropriate to interview the persons who could not think or remember a thing or who were in serious pain.
2. There might have been a possibility of the Hawthorne effect interfering with the patient's objective reporting of data.

All patients selected to participate in the study were healthy enough to understand and respond to questions asked during the interview.

Sample representativeness

There were 279 cancer patients at the Oncology Clinic at Grady Hospital at the time of the study. These patients included 98 patients with breast cancer, 46 patients with leukemia, 50 patients with lung cancer, and 85 patients with cancer of the upper gastro-intestinal tract. It was not possible to include all the patients at the Oncology Clinic in the study because:

1. Not all the patients had terminal cancer. This study dealt with the coping patterns of the interviewed adult terminal cancer patients.

2. Some of the patients with terminal cancer were incoherent in their speech and could not be understood clearly. They either exceeded the age parameters or had experienced brain damage due to cancer.

3. It was considered inappropriate to interview adult terminal cancer patients who were in serious pain.

4. Terminal cancer patients who were below the age of 18 years were not considered adult and, therefore, not included in the study.

Sample selection

The names and addresses of the eligible adult cancer patients were obtained from the research nurses in charge of the various cancer areas of the Oncology Clinic. The four cancer areas used were the breast, leukemia, lung, and upper GI tract (which included cancer of the colon, stomach, esophagus, head and neck, and the unknown primaries).

A simple process of stratified random sampling was carried out to select participants from each of the four groups mentioned. The sampling process involved arranging the names of the patients in each group in alphabetical order. The researcher then selected every third name from the subpopulation of lung and leukemia patients. She also selected every fourth name from the subpopulations of breast and upper GI tract patients. Thus the stratified random sample consisted of 80 patients out of a population of 279 patients. The sample thus selected was considered adequate

and representative of the total patient population at the Grady Memorial Hospital Oncology Clinic.

A stratified random sampling was decided upon because it was thought necessary to include patients from all four cancer groups in the study. All cancer areas were included in order for the entire population of adult terminal cancer patients attending the Oncology Clinic at Grady Memorial Hospital to be represented. A simple random sampling (where all the patients were arranged in alphabetical order and names pulled as one went down the list) might not have provided a representative sample since it would not guarantee that patients from all four cancer areas would be adequately represented.

Table 1 shows the subpopulations and subsamples of patients in each of the four cancer areas in the study.

TABLE 1

SUBPOPULATIONS AND SUBSAMPLES OF CANCER PATIENTS IN THE FOUR CANCER AREAS

Group	Population	Sample
Group A (breast)	98	25
Group B (leukemia)	46	16
Group C (lungs)	50	17
Group D (upper GI tract)	85	22
Total	279	80

The 80 patients in the sample were those who were interviewed for the study. This sample consisted of 32 males and 48 females, or 50 Blacks, 29 Whites, and 1 Puerto Rican. Cases were identified by numbers throughout the study.

Table 2 shows the distribution of the patients' chronological ages by cancer areas.

TABLE 2

DISTRIBUTION OF PATIENTS BY CHRONOLOGICAL AGES AND CANCER AREAS

Age	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
20-29	0	0.0	4	25.00	2	11.76	0	0.00	6	7.50
30-39	2	8.0	1	6.25	0	0.00	2	9.04	5	6.25
40-49	6	24.0	3	18.75	4	23.53	5	22.73	18	22.50
50-59	6	24.0	3	18.75	7	41.18	1	4.54	17	21.25
60-69	8	32.0	3	18.75	3	17.65	7	31.82	21	26.25
70-79	3	12.0	2	12.50	1	5.88	7	31.82	13	16.25
Total	25	100.0	16	100.00	17	100.00	22	100.00	80	100.00

Table 2 contains information about the chronological ages of the patients. The youngest patients in the study were those with leukemia. Their average age was 48.25 years. The oldest patients were those with diagnoses of cancer of the upper gastro-intestinal tract since their mean age was 59.59 years. The breast cancer patients had an average age of 56.10 years and the patients with lung cancer had an average

age of 51.56 years.

Table 3 contains information about the racial description of the patients and their kinds of cancer.

TABLE 3

RACIAL DESCRIPTION OF PATIENTS AND KINDS OF CANCER

Race	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Black	18	72	10	62.50	9	52.9	13	59.1	50	62.50
White	7	28	6	37.50	8	47.1	8	36.4	29	36.25
Puerto Rican	0	0	0	0.00	0	0.0	1	4.5	1	1.25
Total	25	100	16	100.00	17	100.0	22	100.0	80	100.00
Male	1	4	10	62.50	12	70.6	9	40.9	32	40.00
Female	24	96	6	37.50	5	29.4	13	59.1	48	60.00
Total	25	100	16	100.00	17	100.0	22	100.0	80	100.00

As Table 3 indicates, the sample of the study was made up of 50 Blacks, 29 Whites, and 1 Puerto Rican. Eighteen Blacks and 7 Whites had breast cancer. Nine Blacks and eight Whites were in the Oncology Clinic because of lung cancer. The upper gastro-intestinal group of patients was made up of 13 Blacks, 8 Whites, and 1 Puerto Rican. Ten Blacks and 6 Whites had leukemia. The largest number of patients was Blacks. Grady Hospital is designed for persons from the lower socioeconomic group who could not afford private treatment.

Since some Blacks could not afford going to private hospitals they ended up going to Grady.

Table 4 contains information about the marital status of the patients by cancer areas.

TABLE 4

MARITAL STATUS OF THE PATIENTS BY CANCER AREAS

Marital Status	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Single	2	8.0	3	18.75	4	23.52	1	4.55	10	12.50
Married	4	16.0	6	37.50	3	17.65	10	45.45	23	28.75
Divorced	5	20.0	2	12.50	3	17.65	2	9.09	12	15.00
Separated	2	8.0	2	12.50	3	17.65	1	4.55	8	10.00
Widowed	12	48.0	3	18.75	3	17.65	8	36.36	25	32.50
Common-Law	0	0.0	0	0.00	1	5.88	0	0.00	1	1.25
Total	25	100.0	16	100.00	17	100.00	22	100.00	80	100.00

The most salient feature of the data in Table 4 is the fact that the majority of the breast cancer patients were widowed; the majority of the leukemia and upper G.I. patients were married; and the majority of the lung patients were single at the time of the study.

Table 5 contains information about patients' religious affiliations by cancer areas.

TABLE 5

PATIENTS' RELIGIOUS PREFERENCES BY CANCER AREAS

Religious Preferences	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Baptist	20	80	11	68.75	15	88.24	18	81.80	64	80.00
Methodist	4	16	2	12.50	1	5.88	1	4.55	8	10.00
Catholic	0	0	1	6.25	0	0.00	1	4.55	2	2.50
Spiritualist	1	4	0	0.00	0	0.00	0	0.00	1	1.25
Holiness	0	0	1	6.25	1	5.88	1	4.55	3	3.75
Muslim	0	0	1	6.25	0	0.00	0	0.00	1	1.25
Jehovah's Witnesses	0	0	0	0.00	0	0.00	1	4.55	1	1.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

The data in Table 5 indicate that the majority of the patients in each of the four cancer areas belonged to the Baptist Church.

Table 6 contains information about patients' monthly incomes by cancer areas.

The data in Table 6 indicate that patients with leukemia had the largest average monthly income of $301.18. The patients with cancer of the upper G.I. tract had an average monthly income of $261.41, followed by the breast cancer patients with a mean monthly income of $223. The lung patients had the least average monthly income of $215.

TABLE 6

MONTHLY INCOME OF THE PATIENTS BY CANCER AREAS

Monthly Income	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
0-99	3	12.00	2	12.50	5	29.41	1	4.55	11	13.75
100-199	11	44.00	5	31.25	7	41.19	8	36.36	31	38.75
200-299	7	28.00	3	18.75	0	0.00	8	36.36	18	22.50
300-399	2	8.00	2	12.50	2	11.76	1	4.55	7	8.75
400-499	1	4.00	0	0.00	2	11.76	0	0.00	3	3.75
500-599	0	0.00	0	0.00	0	0.00	2	9.09	2	2.50
600-699	0	0.00	3	18.75	1	5.88	2	9.09	6	7.50
700-799	1	4.00	0	0.00	0	0.00	0	0.00	1	1.25
800 or Above	0	0.00	1	6.25	0	0.00	0	0.00	1	1.25
Total	25	100.00	16	100.00	17	100.00	22	100.00	80	100.00

Table 7 contains information about the patients' sources of income and support by cancer areas.

Table 7 indicates that the majority of the patients in each of the four cancer areas reported they were on some kind of public assistance which included Medicaid, Social Security, and General Assistance.

TABLE 7

SOURCES OF PATIENTS' INCOME AND SUPPORT BY CANCER AREAS

Source	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Unemployed	1	4.0	2	12.50	1	5.88	0	0.00	4	5.00
Family	4	16.0	3	18.75	1	5.88	3	13.64	11	13.75
Medicaid	9	36.0	4	25.00	5	29.42	0	0.00	18	22.50
Social Security	5	20.0	3	18.75	1	5.88	8	36.36	17	21.25
General Assistance	3	12.0	1	6.25	6	35.29	3	13.64	13	16.25
Job	3	12.0	3	18.75	3	17.65	1	4.55	10	12.50
Medicare	0	0.0	0	0.00	0	0.00	7	31.81	7	8.75
Total	25	100.0	16	100.00	17	100.00	22	100.00	80	100.00

Table 8 contains information about patients' educational achievements by cancer areas.

The data in Table 8 indicate that nearly all the patients in the study reported they had completed either elementary or high school education.

Table 9 contains information about the patients' occupational status by cancer areas.

The data in Table 9 indicate that the majority of the patients in the four cancer areas had no occupation or were retired workers. Nearly half of the patients with cancer of

TABLE 8

PATIENTS' LEVELS OF EDUCATIONAL ACHIEVEMENTS BY CANCER AREAS

Educational Level	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
College	1	4	1	6.25	1	5.89	1	4.55	5	5.00
High School	11	44	11	68.75	5	29.41	8	36.36	35	43.75
Junior High School	5	20	1	6.25	6	35.29	5	22.73	17	21.25
Elementary School	7	28	3	18.75	5	29.41	8	36.36	23	28.75
No Formal Schooling	1	4	0	0.00	0	0.00	0	0.00	1	1.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

TABLE 9

PATIENTS' OCCUPATIONAL STATUSES BY CANCER AREAS

Occupation	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
None	13	52	6	37.50	10	58.83	9	40.91	38	47.50
Retired	5	20	9	56.25	2	11.76	1	4.54	17	21.25
Blue Collar Workers	3	12	1	6.25	5	29.41	9	40.91	18	22.50
White Collar Workers	4	16	0	0.00	0	0.00	3	13.64	7	8.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

the upper G.I. tract had some kinds of blue and white collar jobs.

Table 10 contains information about the patients' living arrangements by cancer areas.

TABLE 10

PATIENTS' LIVING ARRANGEMENTS BY CANCER AREAS

Living Arrangements	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Spouses	6	24	6	37.50	2	11.76	5	22.72	19	23.75
Children	6	24	2	12.50	2	11.76	3	13.64	13	16.25
Common-Law	0	0	0	0.00	1	5.88	0	0.00	1	1.25
Friends	1	4	3	18.75	1	5.88	3	13.64	8	10.00
Relatives	7	28	2	12.50	6	35.29	7	31.82	22	27.50
Alone	5	20	3	18.75	5	29.42	4	18.18	17	21.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

The data in Table 10 show that the breast patients were living with their spouses, children, or relatives. The leukemia patients lived mostly with their spouses. The lung patients lived either alone or with relatives. The patients with cancer of the upper G.I. tract were living with spouses or relatives.

Table 11 contains information about the patients' household sizes by cancer areas.

TABLE 11

PATIENTS' HOUSEHOLD SIZES BY CANCER AREAS

House-hold Size	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
One Member	5	20	4	25.00	5	29.42	4	18.18	18	22.50
Two Members	12	48	10	62.50	9	52.94	9	40.91	40	50.00
Three Members	3	12	1	6.25	2	11.76	6	27.27	12	15.00
Four Members	1	4	0	0.00	0	0.00	2	9.09	3	3.75
Five Members	1	4	0	0.00	0	0.00	1	4.55	2	2.50
Six Members	2	8	1	6.25	1	5.88	0	0.00	4	5.00
Ten Members	1	4	0	0.00	0	0.00	0	0.00	1	1.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

Table 11 indicates that the majority of the patients in each of the four cancer areas lived in two-member families which were made up of husband and wife.

Table 12 contains information about special equipment provided for patients while they were at home.

The salient characteristics of the data in Table 12 are that with the exception of some patients with cancer of the upper G.I. tract who were provided with walkers, the majority of the patients could get around without special

equipment provided at home.

TABLE 12

SPECIAL EQUIPMENT PROVIDED AT PATIENTS' HOMES BY CANCER AREAS

Equipment	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Hospital Bed	1	4	0	0.00	0	0.00	1	4.55	2	2.50
Wheel Chair	0	0	0	0.00	2	11.76	0	0.00	2	2.50
Walkers	2	8	0	0.00	3	17.65	7	31.82	12	15.00
Crutches	0	0	1	6.25	0	0.00	0	0.00	1	1.25
None	22	88	15	93.75	12	70.59	14	63.64	63	78.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

Table 13 contains information about patients' types of transportation by cancer areas.

The data in Table 13 indicate that the patients in the breast, leukemia, and lung cancer areas depended on their own private cars or the MARTA bus service as modes of transportation. The patients with cancer of the upper G.I. tract made use of their own cars or those of relatives.

Table 14 contains information about patients' leisure-time activities by cancer areas.

The data in Table 14 indicate that while the patients with breast cancer and cancer of the upper G.I. tract employed going to churches as their leisure-time activities, the leukemia

TABLE 13

PATIENTS' TYPES OF TRANSPORTATION BY CANCER AREAS

Types of Transportation	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Own Car	6	24	7	43.75	7	41.18	6	27.27	26	32.50
MARTA Bus	15	60	6	37.50	7	41.18	4	18.18	32	40.00
Taxi	1	4	1	6.25	1	5.88	4	18.18	7	8.75
Relative's Car	2	8	2	12.50	2	11.76	7	31.82	13	16.25
Grady's Bus	0	0	0	0.00	0	0.00	1	4.55	1	1.25
Ambulance	1	4	0	0.00	0	0.00	0	0.00	1	1.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

and lung patients enjoyed sports which included fishing, hunting, tennis, and golfing. Nearly all the lung patients reported they had the habit of smoking. The majority of patients in the other cancer areas reported no habits.

Instruments

The two instruments used in the study were:

1. an Interview Schedule,
2. a Background Information Card.

The Background Information Card is part of the patient's hospital records and provides such data as the patient's age, sex, race, address, income, and marital status. The Interview

TABLE 14

PATIENTS' LEISURE-TIME ACTIVITIES AND HABITS BY CANCER AREAS

Characteristics	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Leisure-Time Activities										
Sports	3	12	6	37.50	9	52.94	3	13.64	21	26.25
Church Activities	12	48	5	31.25	2	11.76	10	45.44	27	36.25
Cooking	1	4	0	0.00	1	5.89	1	4.55	3	3.75
Reading	3	12	2	12.50	0	0.00	1	4.55	6	7.50
Sewing	3	12	0	0.00	2	11.76	4	18.18	9	11.25
Shopping	3	12	1	6.25	0	0.00	2	9.09	6	7.50
None	0	0	2	12.50	3	17.65	1	4.55	6	7.50
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Habit										
Smoking	4	16	3	18.75	16	94.12	3	13.64	26	32.50
Alcohol	1	4	1	6.25	0	0.00	3	13.64	5	6.25
Dips Snuff	1	4	0	0.00	0	0.00	2	9.09	3	3.75
Chews Tobacco	0	0	1	6.25	0	0.00	1	4.55	2	2.50
Drugs	0	0	1	6.25	0	0.00	0	0.00	1	1.25
None	19	76	10	62.50	1	5.88	13	59.08	43	53.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

Schedule was designed by the researcher to elicit information concerning problems encountered by the patients and their coping patterns. A review of the literature reveals that patients with terminal cancer have certain problems that they must cope with. The Interview Schedule was designed to determine whether the patients in the study have similar problems, and, if so, how they dealt with them.

The Interview Schedule

The Interview Schedule was designed to elicit information concerning patients' problems and coping patterns in eight areas:

1. The first area dealt with awareness of diagnosis. Questions that were asked included reactions to diagnosis, problems created by diagnosis, and effectiveness of the solutions of the problems.

2. The second area concerned financial problems of the patients. Questions asked about the patients' financial problems created by illness, solutions to the financial problems, and effectivenss of the solutions.

3. The third area consisted of questions relating to the patient-doctor relationship. Does the patient know his doctor? Does he communicate and feel comfortable with his doctor? Questions are asked about problems created by the patient's relationship with his/her physician, solution to the problems encountered in the relationship with the doctor and satisfaction with the solution.

4. The fourth area of concern involved family attitude toward the patient and his/her diagnosis. Through the use of questions, attempts were made to find out if the patient's family was aware of the diagnosis, how the family reacted initially when it became aware of the diagnosis, whether or not the family's awareness had created any problems for the patient, and what the patient had done about the problems.

5. The fifth area dealt with the psychological problems of the cancer patient. Questions were asked concerning the patient's feelings about having cancer, problems created by his/her feelings, the patient's solution to the problem, and its effectiveness.

6. The sixth area explored the treatment procedure. What treatment is the patient receiving? Has the treatment created any problems for the patient? If "yes," what has he done? How effective are the solutions?

7. The seventh area of interest in the study was the patient's living arrangements. An attempt was made to find out, through questioning, whether or not the patient was satisfied with his living arrangements. Possible areas of dissatisfaction (such as light, heat, and privacy, for example) were explored. Patients were asked to state the solutions they had chosen and the effectiveness of the solutions.

8. The eighth area consisted of a series of questions designed to collect information on the patient's leisure-time activities. The possible sources of problems in the leisure-time activities, hobbies, sex habits, etc. were explored. Patients were asked to state the solutions attempted and the effectiveness of the solutions.

The problem areas were obtained from the review of the literature dealing with patients suffering from cancer and other chronic diseases. In his study of the coping behavior of Nazi concentration camp survivors, Dimsdale demonstrated that the interview is an effective method of studying coping behavior among human beings.[51] Studies dealing with problems created by the patient's awareness of the diagnosis of cancer are found in the literature. The question: "Should the patient know the truth?" should be changed to a challenge: "Am I

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[51]Dimsdale, "The Coping Behavior of Nazi Concentration Camp Survivors," pp. 792-797.

ready and willing . . . to respect equally his/her wish to be told or to be spared?"[52]

Senescu, in the study, "The Development of Emotional Complications in the Patient with Cancer," found that the patient-physician interaction is a most significant factor in the development of emotional complications in cancer patients.[53] Interview schedule questions relating to the attitude of the family toward the patient and his diagnosis, were based on the observations of Bennett and Savov who found that many patients turned to the family and close friends for comfort during crisis.[54]

Questions dealing with the patient's feelings (psychological problems) about cancer were based on Kubler-Ross' position that most people faced with serious illnesses pass through a sequence of behavior: denial, anger, bargaining, depression, and acceptance.[55] Schwartz revealed that chronically ill patients have problems in the areas of living arrangements, housekeeping, shopping, sleeping habits, and leisure-time activities.[56]

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[52]Ilse S. Wolff, "Should the Patient Know the Truth?" American Journal of Nursing, 55 (May, 1955), 546.

[53]Robert A. Senescu, "The Development of Emotional Complications in the Patient with Cancer," Journal of Chronic Diseases, 16 (1961), 813-832.

[54]John B. Bennett and S. E. Savov, "An Experience of Cancer," Harper's Magazine, 247 (November, 1973), 97-98.

[55]Elisabeth Kubler-Ross, On Death and Dying (New York: MacMillan Publishing Co., Inc., 1969), pp. 38-137.

[56]Doris Schwartz, "Nursing Needs of Chronically Ill Ambulatory Patients," Nursing Research, 9 (Fall, 1960), 185.

The eight problem areas were developed following the same format. Each problem area contained two or three questions requiring "yes," "no," or "don't know" answers. A series of open-ended questions requiring patients to state a problem or solution were included. There were two rating scales. These were designed to measure the severity of the problem and the effectiveness of the solution. The two rating scales used were as follows:

1. How would you rate the problem?

   Major problem _____ Mild _____

   Minor problem _____

2. How effective is the solution chosen?

   Very effective _____

   Effective _____

   Not effective _____

   Has worsened problem _____

   Don't know _____

The Background Information Card

The background information was obtained from each patient's records in the Oncology Clinic. It was presented in four categories of information:

1. disease-related: patient's diagnosis, duration of illness, ambulatory status, and special equipment at home;

2. personal: age, sex, race, marital status, religion, and educational level;

3. financial: occupation, amount of monthly income, source of income, and type of transportation;

4. family: living arrangements, household size, leisure-time activities, and habits.

Feasibility Study

After devising the instruments of the study and setting up criteria for eligibility of the study sample, it was necessary to determine whether or not both the director and patients would be willing to participate in the study. The researcher was a social worker in the Oncology Clinic and had frequent contacts with all the terminally ill patients at various times.

A letter was sent to the Director of the Oncology Clinic requesting permission to conduct interviews with the patients and explaining the purpose and scope of the interviews. Special care was taken to explain that the patients' names and diagnoses would not be revealed. A form requesting the Director's permission was attached to the letter, and was to be signed by the Director and returned to the researcher. The form requesting interviews was promptly signed by the Director.

Copies of the Interview Schedule and the Background Information were presented to the Director of the Oncology Clinic. His comments and suggestions, concerning the effectiveness of the instruments, were requested. According to the Director, the Interview Schedule was too long because many of the questions were redundant. He suggested eliminating those questions that were repetitious. The investigator

and director then revised the Interview Schedule, removing items that were vague or redundant. In order to determine whether the patients would be willing to participate in the study, the investigator asked 10 patients at the Oncology Clinic to be interviewed. All accepted and were interviewed.

The feasibility study revealed that:

1. the director was willing to give permission for the study to be conducted,
2. the patients were willing to participate in the study.

Method of Analysis of Data

Response to items in the Interview Schedule were grouped in two broad categories:

1. check list,
2. open-ended and short-answer.

Check list.--Responses to the check list items were carefully tabulated using frequency distribution and percentages.

Open-ended and short-answer.--Responses to the open-ended and short-answer items were first listed on large sheets of paper, and then carefully grouped under broad categories of responses. Frequency distributions and percentages were eventually obtained for these items.

The analysis of data was focused on interpreting data relating to the problems, solutions, coping patterns of the adult terminal cancer patients in terms of the four cancer areas.

Finding answers to the following questions about each of the eight problem areas was the purpose of the analysis of data.

Problems

1. What problems has awareness of diagnosis created for the patients? How would they rate the problem?

2. What financial problems has the illness created for the patients? How would they rate the problems?

3. What problems have the patient-doctor relationships created for the patients? How would they rate the problems?

4. What problems has the families' awareness of the patients' diagnoses created for the patients? How would they rate the problems?

5. What problems have their feelings about cancer created for the patients? How would they rate the problems?

6. What problems have the treatment procedures created for the patients? How would they rate the problems?

7. What problems have living arrangements created for the patients? How would they rate the problems?

8. What problems have leisure-time activities created for the patients? How would they rate the problems?

Solutions and Coping Patterns

1. How does the patient solve the problems created by awareness of diagnosis? How effective is the solution?

2. How does the patient solve the financial problems created by the illness? How effective is the solution?

3. How does the patient solve the problems created by the patient-doctor relationship. How effective is the solution?

4. How does the patient solve the problems created by family awareness of diagnosis? How effective is the solution?

5. How does the patient solve the problems created by the patient's feelings about cancer? How effective is the solution?

6. How does the patient solve the problems created by the treatment procedures? How effective is the solution?

7. How does the patient solve the problems created by living arrangements? How effective is the solution?

8. How does the patient solve the problems created by leisure-time activities? How effective is the solution?

Summary

Chapter III has dealt with a description of the design and methods of procedures used in this study with respect to (1) the subjects, (2) the instruments, (3) the data collection, and (4) treatment of the data.

The subjects were terminal cancer patients, ages 18 and above, who received treatment at the Oncology Clinic of Grady Memorial Hospital, Atlanta, Georgia. The subjects were selected through a stratified random sampling procedure from a population of 279 cancer patients at the Oncology Clinic at the time of this study. The sample consisted of 25 breast cancer patients, 16 leukemia patients, 17 lung cancer patients, and 22 patients with cancer of the upper gastro-intestinal tract. There were 32 males and 48 females. Fifty patients were Black, twenty-nine White, and one Puerto Rican.

The instruments used in the study were the Interview Schedule and the Background Information Card. The researcher designed the Interview Schedule which was used to elicit information concerning patients' problems, coping patterns, and their ratings of effectiveness of solutions used. Patients were asked questions concerning problems caused by their awareness of diagnoses, finances, family attitudes, patient-doctor relationships, treatment procedures, living arrangements, psychological problems, and leisure-time activities. The Background Information Card was part of the patients' hospital records and provided information as to the patient's age, race, sex, income, and marital status.

Data was collected primarily from responses to items in the Interview Schedule. Responses were in the form of check list, open-ended, and short answer. Patients were asked questions in eight problem areas. Their solutions to the problems were noted. Rating scales were used to determine the effectiveness of their solutions.

The treatment of the data was focused on interpreting data relating to the problems, solutions, and ratings of effectiveness of solutions. Responses to the check list items were carefully tabulated using frequency distributions and percentages. Responses to the open-ended and short answer items were carefully grouped under broad categories of responses. Frequency distributions and percentages were eventually obtained for these items.

CHAPTER IV

FINDINGS AND INTERPRETATIONS

The purpose of this chapter is to present and analyze the data of the study. The Interview Schedule provided the primary instrument for gathering the data. Data was gathered on (1) problems encountered by the cancer patients in the study, (2) the solutions or coping patterns utilized by these patients, (3) the patients' ratings of the effectiveness of their solutions.

Problems Encountered by Cancer Patients

The patients were asked to describe their initial reactions to having cancer, the changes in their initial reactions, and the ways in which their reactions had changed since the diagnoses.

The reason for reporting the patients' initial reactions and changes in reactions is to test a thesis that a patient's reactions to his diagnosis will affect how well he copes with the disease. Holland observed that the diagnosis of cancer produces several reactions that include threat of death, fear, and uncertainty.[57]

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[57]Holland, "Coping with Cancer," pp. 3-19.

Table 15 shows problems patients encountered by cancer areas.

Fourteen (87.5%) of the leukemia patients experienced problems when they became aware of their diagnoses. Twenty-one (84%) of the patients with cancer of the breast reported having problems with their diagnoses. Fourteen (82.35%) of the patients with lung cancer reported that they had problems when they found they had cancer. Seventeen (77.27%) of the patients with cancer of the upper gastro-intestinal tract experienced problems with their diagnoses. The majority of patients in each of the four cancer areas reported that the awareness of the diagnosis of cancer had created a problem for them. They were afraid that having cancer would create loss of friends and loved ones. Findings in the literature indicated that people with the diagnosis of cancer often viewed their illness as a type of "stigma."[58]

Cancer was also viewed as a contagious disease that could contaminate others who associated with cancer patients.[59]

Twenty-three (92%) of the breast patients felt that the attitudes of their families had created problems for them. Sixteen (100%) of the leukemia patients complained that family attitudes toward their diagnoses had been negative. Seventeen

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[58]Goffman, Stigma, pp. 1-3.

[59]Daniel Horn and Selwyn Waingrow, "What Changes Are Occurring in Public Opinion Toward Cancer: National Public Opinion Survey," American Journal of Public Health, 54 (March, 1964), 431-440.

TABLE 15

PROBLEMS PATIENTS ENCOUNTERED BY CANCER AREAS

Characteristic	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness of Diagnosis										
Encountered Problems	21	84	14	87.50	14	82.35	17	77.27	66	82.50
Did Not Encounter Problems	4	16	2	12.50	3	17.65	5	22.73	14	17.50
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Family Attitudes										
Encountered Problems	23	92	16	100.00	12	70.59	17	77.27	68	85.00
Did Not Encounter Problems	2	8	0	0.00	5	29.41	5	22.73	12	15.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Patient-Doctor Relationships										
Encountered Problems	17	68	11	68.75	14	82.35	22	100.00	64	80.00
Did Not Encounter Problems	8	32	5	31.25	3	17.65	0	0.00	16	20.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

TABLE 15--Continued

Characteristic	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Financial Problems										
Encountered Problems	19	76	14	87.50	17	100.00	17	77.27	67	83.75
Did Not Encounter Problems	6	24	2	12.50	0	0.00	5	22.73	13	16.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Psychological Problems										
Encountered Problems	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Did Not Encounter Problems	0	0	0	0.00	0	0.00	0	0.00	0	0.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Leisure-Time Activities										
Encountered Problems	25	100	14	87.50	17	100.00	21	95.45	77	96.25
Did Not Encounter Problems	0	0	2	12.50	0	0.00	1	4.55	3	3.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Living Arrangements										
Encountered Problems	10	40	5	31.25	8	47.06	6	27.27	29	36.25
Did Not Encounter Problems	15	60	11	68.75	9	52.94	16	72.73	51	63.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

TABLE 15--Continued

Characteristic	Breast No.	%	Leukemia No.	%	Lung No.	%	Upper G.I. No.	%	Total No.	%
Treatment Procedures										
Encountered Problems	25	100	16	100.00	16	94.12	22	100.00	79	98.75
Did Not Encounter Problems	0	0	0	0.00	1	5.88	0	0.00	1	1.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

(77.27%) patients with cancer of the upper G.I. tract and twelve (70.59%) patients with lung cancer reported that problems had been created by the family attitudes toward their diagnoses. The majority of patients in each of the four cancer areas reported having problems with family attitudes toward their diagnoses. Research findings indicated that both the patient and his family are traumatized by a diagnosis of cancer. The reactions of the family toward the diagnosis affect the patient's response to his illness as well as the relationship between family members and the patient.[60]

Twenty-two (100%) of the upper G.I. patients encountered problems when relating to their doctors. Fourteen (82.35%) of the lung patients had problems in relationships with their physicians. Eleven (68.75%) of the leukemia patients reported problems in relating to their doctors. Seventeen (68%) of the breast patients stated that they had problems with their doctors.

The majority of the patients in the four cancer areas reported that they had problems in relationships with their doctors. Findings in the literature indicated that when doctors had inadequate rapport with their patients, problems occurred such as poor communication and lack of trust. It was also stated in the literature that physicians who had much anxiety while talking to cancer patients had a tendency to omit certain vital points thus leading to misunderstandings

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[60]Vettese, "Problems of the Patient," pp. 3-19.

between patient and doctor.[61]

Seventeen (100%) of the lung patients encountered financial problems. Fourteen (87.5%) of the leukemia patients reported that they had financial problems. Seventeen (77.27%) of the upper G.I. patients stated that finances created problems for them. Nineteen (76%) of the breast patients experienced financial problems. Findings in the literature indicated that family members caring for cancer patients at home had problems with finances.[62]

All the patients in the four cancer areas displayed psychological problems as a result of having cancer. The psychological problems experienced by these patients included (1) anger, (2) guilt, (3) anxiety, (4) fear of death, (5) pain and confinement, and (6) embarrassment.

Findings in the literature revealed that cancer terrorizes patients, evoking fear, the image of invalidism, incapacity and death, regardless of the actual prognosis and available treatment.[63]

Twenty-five (100%) of the breast patients experienced problems with leisure-time activities. Seventeen (100%) of the lung patients encountered problems with leisure-time activities. Twenty-one (95.45%) of the upper G.I. patients had

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[61]Hayes, "The Impact of the Health-Care System," pp. 1-169.

[62]Lepper, "Problems and Coping Patterns," pp. 88-89.

[63]Weisman, "Coping Behavior and Suicide," pp. 3-9.

problems with leisure-time activities. Fourteen (87.5%) of the leukemia patients reported problems with leisure-time activities.

The majority of patients in all the four cancer areas experienced problems in their leisure-time activities which included church activities, hobbies, housekeeping, and sex.

Findings in the literature indicated that cancer has detrimental effects on husband-wife relationships. The cancer patient frequently had problems with his/her spouse regarding sexual intercourse.[64]

Eight (47.06%) of the lung patients had problems with living arrangements. Ten (40%) of the breast patients experienced problems with living arrangements. Five (31.25%) of the leukemia patients reported problems with living arrangements. Six (27.27%) of the upper G.I. patients encountered problems with living arrangements. Although patients experienced problems in this area, the majority of the patients did not encounter problems with living arrangements. Those patients who had problems with their living arrangements, often complained of lack of space or privacy, roaches, poor heating system, noise, and stairs to climb. Findings in the literature indicated that family members caring for cancer patients at home had problems with lack of space, sleeping arrangements, and inadequate housing.[65]

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[64]Dyk and Sutherland, "Adaptation of the Spouse," pp. 74-87.

[65]Lepper, "Problems and Coping Patterns," pp. 88-89.

Sixteen (100%) of the leukemia patients had problems with treatment procedures. Twenty-two (100%) upper G.I. patients experienced problems with treatment procedures. Twenty-five (100%) breast patients stated that they had problems with treatment procedures. Sixteen (94.12%) lung patients encountered problems with treatment procedures.

The majority of the patients had problems with such treatment procedures as weakness, nausea, and vomiting. The other patients complained of loss of hair, decreased appetite and reduced sexual activity. Findings in the literature indicated that radiation therapy could be stressful and frightening to patients. The literature also showed that patients who had surgery were mainly afraid of losing their normal bodily functions and afraid of their bodies becoming mutilated.[66]

Solutions or Coping Patterns Utilized by Patients

Table 16 shows how the patients attempted to cope with and solve the problems created by their illnesses.

In the area of problems created by awareness of diagnosis, patients attempted solutions such as becoming pessimistic and angry toward other people. Twenty (80%) breast patients and nine (52.9%) lung patients attempted these solutions, while twenty (90.91%) upper G.I. patients and eleven

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[66]Vettese, "Problems of the Patient," pp. 1-169.

TABLE 16

DISTRIBUTION OF COPING PATTERNS OF PATIENTS BY CANCER AREAS

Characteristics	Breast		Leukemia		Lung		Upper G.I.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness of Diagnosis										
Attempted some solutions	20	80	5	31.25	9	52.90	2	9.09	36	45.00
Did not attempt solutions	5	20	11	68.75	8	47.10	20	90.91	44	55.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Family Attitudes										
Attempted some solutions	8	32	11	68.75	10	58.80	5	22.70	34	42.50
Did not attempt solutions	17	68	5	31.25	7	41.20	17	77.30	46	57.50
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Patient-Doctor Relationships										
Attempted some solutions	4	16	13	81.25	7	41.20	3	13.60	27	33.75
Did not attempt solutions	21	84	3	18.75	10	58.80	19	86.40	53	66.25
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

TABLE 16--Continued

Characteristics	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Financial Problems										
Attempted some solutions	19	76	14	87.50	8	47.10	11	50.00	42	52.50
Did not attempt solutions	6	24	2	12.50	9	52.90	11	50.00	38	47.50
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Psychological Problems										
Attempted some solutions	4	16	14	87.50	1	5.90	2	9.09	21	26.25
Did not attempt solutions	21	84	2	12.50	16	94.10	20	90.91	59	73.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Leisure-Time Activities										
Attempted some solutions	18	72	11	68.75	9	52.90	3	13.60	41	51.25
Did not attempt solutions	7	28	5	31.25	8	47.10	19	86.40	39	48.75
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00
Living Arrangements										
Attempted some solutions	15	60	14	87.50	10	58.80	17	77.30	56	70.00
Did not attempt solutions	10	40	2	12.50	7	41.20	5	22.70	24	30.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

TABLE 16--Continued

Characteristics	Breast No.	Breast %	Leukemia No.	Leukemia %	Lung No.	Lung %	Upper G.I. No.	Upper G.I. %	Total No.	Total %
Treatment Procedures										
Attempted some solutions	7	28	9	56.25	14	82.40	2	9.09	32	40.00
Did not attempt solutions	18	72	7	43.75	3	17.60	20	90.91	48	60.00
Total	25	100	16	100.00	17	100.00	22	100.00	80	100.00

(68.75%) leukemia patients did not attempt any solutions.

Findings in the literature revealed that terminal cancer patients, when becoming aware of their diagnoses, attempted solutions by reading extensively and trying to find out more information about the disease.[67]

In the area of problems created by family attitudes toward their diagnoses, patients responded by becoming hostile toward their family members, by asking family members to stop being overprotective, by demanding independence and no interference from family members, or by discussing problems freely with interested family members. Eleven (68.75%) leukemia patients and ten (58.8%) lung patients attempted some solutions. Seventeen (68%) breast patients did not attempt any solutions.

In the area of problems created by patient-doctor relationships, patients attempted solutions such as asking to see the same doctor rather than changing doctors, asking for older and more experienced doctors, and telling doctors to stop experimenting on them. Thirteen (81.25%) leukemia patients attempted such solutions. No solutions were attempted by nineteen (86.4%) patients with cancer of the upper gastrointestinal tract nor was any solution made by twenty-one (84%) breast patients or by ten (58.8%) lung patients.

Patients who were faced with financial problems attempted solutions by applying for assistance from Welfare,

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[67]Klagsburn, "Communications in the Treatment of Cancer," pp. 944-948.

American Cancer Society, and Unemployment Compensation, or by asking relatives for money. Those who attempted solutions in this problem area included fourteen (87.5%) leukemia patients, and nineteen (76%) breast patients. Nine (52.9%) lung patients and eleven (50%) upper gastro-intestinal patients did not attempt any solutions.

Patients solved the psychological problems associated with cancer by seeing psychiatrists, developing stronger beliefs in God, by threatening suicide, or by making plans for a nursing home. Fourteen (87.5%) leukemia patients attempted such solutions. No attempts at solutions were made by sixteen (94.1%) lung patients, by twenty (90.91%) upper gastro-intestinal tract patients, or by twenty-one (84%) breast patients. Findings in the literature revealed that terminal cancer patients, in attempting to cope with psychological problems, employed a belief in a divine purpose or in the general beneficence of a divine spirit.[68]

Keeping up with leisure-time activities presented problems for the patients. The patients solved their problems by attempting to discontinue treatment, by using alcohol, by asking ministers and friends for help, or by talking with doctors about sex habits. Such solutions were attempted by eighteen (72%) breast patients, by eleven (68.75%) leukemia patients, and by nine (52.9%) lung patients. Nineteen (86.4%)

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[68]Rudolph H. Moos and Vivien D. Tsu, "The Crisis of Physical Illness: An Overview," in Coping with Physical Illness, ed. by Rudolf H. Moos (New York: Plenum Medical Book Co., 1977), pp. 12-15.

patients with cancer of the upper gastro-intestinal tract did not attempt any solutions. Findings in the literature revealed that patients attempted to cope with sexual problems by avoiding or discontinuing sexual intercourse with their partners.[69]

Patients had problems with living arrangements. They attempted such solutions as applying for more comfortable apartments, reducing inconveniences by asking relatives to move out, and by complaining to everyone about problems created by poor living arrangements. Such solutions were employed by fourteen (87.5%) leukemia patients, by seventeen (77.3%) patients with cancer of the upper gastro-intestinal tract, by fifteen (60.9%) breast patients, and by ten (58.8%) lung patients.

In the area of problems created by their treatment procedures, patients attempted such solutions as threatening to discontinue treatment, using alcohol excessively, and complaining about the "sickening" treatment conditions. Fourteen (82.4%) lung patients and nine (56.25%) leukemia patients attempted some solutions. Eighteen (72%) breast patients and twenty (90.91%) patients with cancer of the upper gastro-intestinal tract did not attempt any solutions.

Patients' Ratings of Effectiveness of Their Solutions

Table 17 shows how the patients rated the effectiveness

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[69]Dyk and Sutherland, "Adaptation of the Spouse," pp. 74-87.

TABLE 17

PATIENTS' RATINGS OF EFFECTIVENESS OF SOLUTIONS

Problem Area	Effectiveness of Solutions		
	Very Effective or Effective	Not Effective or Had Worsened Problems	No Solutions Attempted
Awareness of Diagnoses	Lung 4 (23.53%) Breast 3 (12.0%) Leukemia 1 (6.25%)	Breast 17 (68.0%) Lung 5 (29.41%) Leukemia 4 (25.0%) Upper G.I. 2 (9.1%)	Upper G.I. 20 (90.9%) Leukemia 11 (68.75%) Lung 8 (47.06%) Breast 5 (20.0%)
Family Attitudes	Leukemia 4 (25.0%) Breast 2 (8.0%) Lung 2 (11.76%) Upper G.I. 1 (4.55%)	Lung 8 (47.06%) Leukemia 7 (43.75%) Breast 6 (24.0%) Upper G.I. 4 (18.18%)	Upper G.I. 17 (77.27%) Breast 17 (68.0%) Lung 7 (41.18%) Leukemia 5 (31.25%)
Patient-Doctor Relationships	Leukemia 5 (31.25%)	Leukemia 8 (50.0%) Lung 7 (41.17%) Breast 4 (16.0%) Upper G.I. 3 (13.64%)	Upper G.I. 19 (86.36%) Breast 21 (84.0%) Lung 10 (58.83%) Leukemia 3 (18.75%)
Financial Problems	Leukemia 6 (37.5%) Breast 5 (20.0%) Lung 5 (29.41%) Upper G.I. 2 (9.09%)	Breast 14 (56.0%) Leukemia 8 (50.0%) Upper G.I. 9 (40.91%) Lung 3 (17.65%)	Lung 9 (52.94%) Upper G.I. 11 (50.0%) Breast 6 (24.0%) Leukemia 2 (12.5%)

TABLE 17--Continued

Problem Area	Effectiveness of Solutions		
	Very Effective or Effective	Not Effective or Had Worsened Problems	No Solutions Attempted
Psychological Problems	Leukemia 3 (18.75%) Breast 3 (12.0%)	Leukemia 11 (68.75%) Upper G.I. 2 (9.09%) Lung 1 (5.88%) Breast 1 (4.0%)	Lung 16 (94.12%) Upper G.I. 20 (90.9%) Breast 21 (84.0%) Leukemia 2 (12.5%)
Leisure-Time Activities	Breast 5 (20.0%) Leukemia 3 (18.75%) Lung 1 (5.88%) Upper G.I. 1 (4.55%)	Breast 13 (52.0%) Leukemia 8 (50.0%) Lung 8 (47.06%) Upper G.I. 1 (4.55%)	Upper G.I. 19 (86.36%) Lung 8 (47.06%) Leukemia 5 (31.25%) Breast 7 (28.0%)
Living Arrangements	Upper G.I. 2 (13.09%) Leukemia 1 (6.25%) Lung 2 (11.76%) Breast 2 (8.0%)	Leukemia 13 (81.25%) Upper G.I. 14 (63.64%) Breast 13 (52.0%) Lung 8 (47.06%)	Lung 7 (41.18%) Breast 10 (40.0%) Upper G.I. 5 (22.72%) Leukemia 2 (12.5%)
Treatment Procedure	Leukemia 5 (31.25%) Lung 4 (23.52%) Breast 3 (12.0%) Upper G.I. 1 (4.55%)	Lung 10 (58.83%) Leukemia 4 (25%) Breast 4 (16.0%) Upper G.I. 1 (4.55%)	Upper G.I. 20 (90.9%) Breast 18 (72.0%) Leukemia 7 (43.75%) Lung 3 (17.65%)

of the solutions they used in each of the eight problem areas.

The patients solved problems caused by their awareness of diagnoses by becoming pessimistic or angry toward other people. These solutions were rated very effective or effective by four (23.53%) lung patients, three (12.0%) breast patients, and one (6.25%) leukemia patient.

Five (29.41%) lung patients, four (25%) leukemia patients, and two (9.1%) upper G.I. patients felt that the solutions were not effective or had worsened the problem.

In the area of problems created by family attitudes, patients solved their problems by becoming hostile toward their family members, asking family members to stop being overprotective, demanding independence from family members, or by discussing the problems freely with family members. These solutions were rated very effective and effective by four (25%) leukemia patients, two (8%) breast patients, two (11.76%) lung patients, and one (4.55%) upper G.I. patient. The following patients rated the solutions not effective or had worsened the problems: eight (47.06%) lung patients, seven (43.75%) leukemia patients, six (24%) breast patients, and four (18.18%) upper G.I. patients.

The patients solved problems caused by patient-doctor relationships by asking to see the same doctor again, asking for older doctors, complaining to doctors and asking doctors to stop experimenting on them. These solutions were rated effective by five (31.25%) leukemia patients. The following

patients rated their solutions as not effective or had worsened the problems: eight (50%) leukemia patients, seven (41.17%) lung patients, four (16%) breast patients, and three (13.64%) upper G.I. patients.

The patients solved problems created by finances by applying for Welfare, seeking assistance from American Cancer Society, Unemployment Compensation, or by asking relatives for money. These solutions were rated very effective or effective by six (37.5%) leukemia patients, five (29.41%) lung patients, five (20%) breast patients, and two (9.09%) upper G.I. patients. The following patients felt that the solutions were not effective or had worsened their problems: fourteen (56%) breast patients, eight (50%) leukemia patients, nine (40.91%) upper G.I. patients, and three (17.65%) lung patients.

The patients attempted to solve their psychological problems by seeing psychiatrists, developing stronger beliefs in God, threatening suicide, or by making plans for a nursing home. These solutions were rated very effective or effective by three (18.75%) leukemia patients and three (12%) breast patients. Eleven (68.75%) leukemia patients, two (9.09%) upper G.I. patients, one (5.88%) lung patient, and one (4%) breast patient felt that the solutions were not effective or had worsened their problems.

The patients solved problems created by leisure-time activities by attempting to discontinue treatment, using

alcohol, asking ministers and friends for help, or by talking with doctors about sex habits. These solutions were rated very effective or effective by five (20%) breast patients, three (18.75%) leukemia patients, one (5.88%) lung patient, and one (4.55%) upper G.I. patient. Thirteen (52%) breast patients, eight (50%) leukemia patients, eight (47.06%) lung patients, and one (4.55%) upper G.I. patient stated that the solutions were not effective or had worsened the problem.

In the area of living arrangements, patients attempted to solve problems by applying for more comfortable apartments, asking relatives to move out, or complaining about problems created by poor living arrangements. These solutions were rated very effective or effective by two (13.09%) upper G.I. patients, two (11.76%) lung patients, two (8%) breast patients, and one (6.25%) leukemia patient. Solutions were rated not effective or had worsened problems by thirteen (81.25%) leukemia patients, fourteen (63.64%) upper G.I. patients, thirteen (52%) breast patients, and eight (47.06%) lung patients.

The patients solved problems caused by treatment procedures by threatening to discontinue treatment, complaining about the methods of treatment, or using excessive alcohol. These solutions were rated very effective or effective by five (31.25%) leukemia patients, four (23.52%) lung patients, three (12%) breast patients, and one (4.55%) upper G.I. patient. Solutions were not effective or had worsened problems

for ten (58.83%) lung patients, four (25%) leukemia patients, four (16%) breast patients, and one (4.55%) upper G.I. patient.

Summary

In the analysis of data, the first interest was to determine the problems experienced by the patients in these eight problem areas: awareness of diagnosis, family attitudes, patient-doctor relationships, finances, psychological problems, leisure-time activities, living arrangements, and treatment procedures.

In the area of awareness of diagnosis, fourteen (87.5%) leukemia patients, twenty-one (84%) breast patients, fourteen (82.35%) lung patients, and seventeen (77.27%) upper gastrointestinal patients experienced problems when they became aware of their diagnoses. In the area of family attitudes, twenty-three (92%) breast patients and sixteen (100%) leukemia patients experienced problems. Seventeen (77.27%) upper G.I. patients and twelve (70.59%) lung cancer patients also experienced problems with family attitudes. In the third problem area of patient-doctor relationships, twenty-two (100%) upper G.I. patients and fourteen (82.35%) lung patients encountered problems. Eleven (68.75%) leukemia patients and seventeen (68%) breast patients also encountered problems in this area. Seventeen (100%) lung patients, fourteen (87.5%) leukemia patients, seventeen (77.27%) upper G.I.

patients, and nineteen (76%) breast patients experienced financial problems. All the patients in the four cancer areas experienced psychological problems as a result of having cancer. In the area of leisure-time activities, twenty-five (100%) breast patients, seventeen (100%) lung patients, twenty-one (95.45%) upper G.I. patients, and fourteen (87.5%) leukemia patients encountered problems. Eight (47.06%) lung patients and ten (40%) breast patients had problems with living arrangements. Five (31.25%) leukemia patients and six (27.27%) upper G.I. patients also had problems with living arrangements. In the problem area of treatment procedures, sixteen (100%) leukemia patients, twenty-two (100%) upper G.I. patients, twenty-five (100%) breast patients, and sixteen (94.12%) lung patients experienced problems.

In analyzing the data, the next area of concern was to examine the coping patterns or solutions utilized by patients in each of the four cancer groups.

In the problem area of awareness of diagnosis, twenty (80%) breast patients and nine (52.9%) lung patients attempted solutions such as becoming pessimistic and angry toward other people. Twenty (90.91%) upper G.I. patients and eleven (68.75%) leukemia patients did not attempt any solutions to this problem. In the area of family attitudes, eleven (68.75%) leukemia patients and ten (58.8%) lung patients attempted solutions such as becoming hostile toward their

families, asking family members to stop being overprotective, demanding independence from their families, and by discussing problems freely with interested family members. On the other hand, seventeen (77.3%) upper G.I. patients and seventeen (68%) breast patients did not attempt any solutions to this problem. In the area of patient-doctor relationships, thirteen (81.25%) leukemia patients attempted solutions such as asking to see the same doctor again, asking for older and more experienced doctors, and telling doctors to stop experimenting on them. Nineteen (86.4%) upper G.I. patients, twenty-one (84%) breast patients, and ten (58.8%) lung patients did not attempt any solutions to this problem. Those who attempted solutions to financial problems were fourteen (87.5%) leukemia patients and nineteen (76%) breast patients. Their solutions were applying for assistance from Welfare, American Cancer Society, Unemployment Compensation, or by asking relatives for money. Those who did not attempt any solutions to this problem were nine (52.9%) lung patients and eleven (50%) upper G.I. patients. In the area of psychological problems, fourteen (87.5%) leukemia patients attempted solutions to this problem by seeing psychiatrists, developing stronger beliefs in God, threatening suicide, or by making plans for a nursing home. Sixteen (94.1%) lung patients, twenty (90.91%) upper G.I. patients, and twenty-one (84%) breast patients made no attempts to solve problems in this area.

In the problem area, leisure-time activities, eighteen (72%) breast patients, eleven (68.75%) leukemia patients, and nine (52.9%) lung patients attempted solutions such as discontinuing treatment, using alcohol, asking ministers and friends for help or by talking with doctors about sex habits. Nineteen (86.4%) upper G.I. patients did not attempt any solutions to this problem. In dealing with the problem of living arrangements, fourteen (87.5%) leukemia patients, seventeen (77.3%) upper G.I. patients, fifteen (60%) breast patients, and ten (58.8%) lung patients attempted solutions to this problem, such as applying for more comfortable apartments, asking relatives to move out,and complaining about problems created by poor living arrangements. No solutions to this problem were attempted by seven (41.2%) lung patients, ten (40%) breast patients, five (22.7%) upper G.I. patients, and two (12.5%) leukemia patients. In the last problem area of treatment procedures, fourteen (82.4%) lung patients, and nine (56.25%) leukemia patients attempted solutions to this problem by threatening to discontinue treatment, using alcohol excessively, and complaining about the "sickening" treatment they were receiving. Those patients who did not attempt any solutions to this problem were eighteen (72%) breast patients and twenty (90.91%) upper G.I. patients.

The last area of concern in analyzing the data was to examine the patients' ratings of the effectiveness of their solutions to problems created by cancer.

In the problem area of awareness of diagnosis, four (23.53%) lung patients, three (12%) breast patients, and one (6.25%) leukemia patient rated their solutions as very effective or effective while five (29.41%) lung patients, four (25%) leukemia patients, and two (9.1%) upper G.I. patients felt their solutions were not effective or had worsened the problem.

In the problem area of family attitudes, four (25%) leukemia patients, two (11.76%) lung patients, and one (4.55%) upper G.I. patient rated their solutions as very effective or effective. Eight (47.06%) lung patients, seven (43.75%) leukemia patients, six (24%) breast patients, and four (18.18%) upper G.I. patients rated their solutions as not effective or had worsened the problem.

In dealing with problems with their physicians, five (31.25%) leukemia patients rated their solutions as very effective or effective. Eight (50%) leukemia patients, seven (41.17%) lung patients, four (16%) breast patients, and three (13.64%) upper G.I. patients rated their solutions as not effective or had worsened the problem.

In the problem area of finances, six (37.5%) leukemia patients, five (29.41%) lung patients, five (20%) breast patients, and two (9.09%) upper G.I. patients rated their solutions as very effective or effective. Fourteen (56%) breast patients, eight (50%) leukemia patients, nine (40.91%) upper G.I. patients, and three (17.65%) lung patients rated their

solutions as not effective or had worsened the problem. Solutions to psychological problems were rated very effective or effective by three (18.75%) leukemia patients and three (12%) breast patients. Eleven (68.75%) leukemia patients, two (9.09%) upper G.I. patients, one (5.88%) lung patient, and one (4%) breast patient felt that the solutions were not effective or had worsened the problem. Solutions to problems created by leisure-time activities were rated very effective or effective by five (20%) breast patients, three (18.75%) leukemia patients, one (5.88%) lung patient, and one (4.55%) upper G.I. patient. Thirteen (52%) breast patients, eight (50%) leukemia patients, eight (47.06%) lung patients, and one (4.55%) upper G.I. patient rated the solutions as not effective or had worsened the problem. In the problem area of living arrangements, solutions were rated very effective or effective by two (13.09%) upper G.I. patients, two (11.76%) lung patients, two (8%) breast patients, and one (6.25%) leukemia patient. Thirteen (81.25%) leukemia patients, fourteen (63.64%) upper G.I. patients, thirteen (52%) breast patients, and eight (47.06%) lung patients rated the solutions not effective or had worsened the problem. In the last problem area of treatment procedures, solutions were rated very effective or effective by five (31.25%) leukemia patients, four (23.52%) lung patinets, three (12%) breast patients, and one (4.55%) upper G.I. patient. Solutions were rated not effective or had worsened the problems by

ten (58.83%) lung patients, four (25%) leukemia patients, four (16%) breast patients, and one (4.55%) upper G.I. patient.

CHAPTER V

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This study was designed to describe and analyze problems and coping patterns of a sample of adult terminal cancer patients in the Oncology Clinic at Grady Memorial Hospital, Atlanta, Georgia.

Purposes of the Study

Specifically, this study was made to:

1. determine the problems adult terminal cancer patients experienced at the Oncology Clinic at Grady Memorial Hospital, Atlanta, Georgia;
2. identify and analyze the coping patterns of the patients;
3. assess the patients' ratings of the effectiveness of the solutions.

Subjects, Methodology, and Instruments

The subjects were 80 terminal cancer patients, chronological ages 18 and above, who received treatment at the Oncology Clinic of Grady Hospital. Thirty-two were males and 48 were females. Fifty were Black, twenty-nine were White, and one was Puerto Rican. Four types of cancer were used, namely, breast, leukemia, lung, and upper gastro-intestinal

tract. A stratified random sample was chosen consisting of 80 participants.

The instruments used were an Interview Schedule and a Background Information Card. This latter instrument provided information on the patient's age, sex, race, address, income, and marital status. The Interview Schedule was used to acquire information about problems patients encountered in their coping efforts.

Information was obtained on eight types of problem areas: (1) patients' reactions to awareness of diagnosis, (2) patient's financial problems, (3) patient-doctor relationships, (4) family attitudes toward patient and his/her diagnosis, (5) patients' psychological problems, (6) treatment procedures, (7) patients' living arrangements, and (8) patients' leisure-time activities.

Conclusions

The findings acquired from the analysis of the data seem to warrant the conclusions listed below:

1. The patients in each of the four cancer areas seemed to encounter different problems; however, all the patients encountered psychological problems due to their diagnoses.

2. Breast cancer patients tended to experience problems mainly with leisure-time activities, treatment procedures, and psychological problems. Leukemia patients appeared to have problems with finances, leisure-time activities, and psychological problems. Upper gastro-intestinal patients appeared to have problems mainly with their physicians, treatment procedures, and psychological problems.

3. The patients in the four cancer areas differed in their attempts to solve problems created by their illnesses.

4. Breast cancer patients seemed to attempt solutions to awareness of diagnosis, financial problems, and leisure-time activities. Leukemia patients tended to attempt solutions to problems with their physicians, finances, living arrangements, and psychological problems. Lung patients mainly attempted solutions to treatment procedures. Upper gastrointestinal patients appeared to attempt solutions mainly to problems of living arrangements.

5. As a whole, patients in the four cancer areas tended to rate the solutions to their problems as not effective or making the problem worse.

Implications

Implications of this study evolved from the analysis of the data collected and from the researcher's experiences in person-to-person contacts with the adult terminal cancer patients at the Oncology Clinic. It is probable that these implications would not have been drawn by another researcher. From the researcher's point of view, the following implications are presented:

1. It was revealed that all the patients in the four cancer areas experienced psychological problems due to their diagnoses. This could be accounted for because the diagnosis of cancer tends to produce fear of death and pain in patients.

2. Leukemia patients seemed to have made better overall attempts to develop solutions to their problems than patients in the other cancer areas. Generally, few people in society realize that leukemia is a type of cancer. Less stigma might be attached to patients with leukemia. Therefore, patients with leukemia seemed more optimistic and attempted to solve their problems more readily than patients with other types of cancer.

Recommendations for Future Research

The above implications and conclusions suggest a need for further research in the following areas:

1. a comparative study of patients at a private hospital such as Crawford Long Hospital to determine if socio-economic status has influences on coping patterns of the patients. Do cancer patients in a private hospital have the same problems as cancer patients in a teaching hospital? Does the medical staff relate to cancer patients in both settings in similar ways?

2. a comparative study of male and female cancer patients to determine if they use similar methods in coping with cancer;

3. an investigation of the religion of each cancer patient to see if religion affects coping patterns;

4. a comparative study of White and Black cancer patients to determine if race has an effect on the coping methods employed;

5. a replication of this study using large numbers of cancer patients from other hospitals in Atlanta or the Southeast to improve the generalizability of the findings;

6. an investigation of patients' attitudes toward death to see if this affects their coping patterns.

APPENDIX A

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

Patient's Name:_____

Age: _____ Sex: _____

I. Awareness of Diagnosis

a. Is patient aware of his diagnosis? If the patient knows the diagnosis, ask the following questions:

1. When did he first find out the diagnosis?
2. Who told him, and what did they say?
3. What was his initial reaction?
4. Has this reaction changed since?
   Yes___No___Don't Know___
5. In what way(s) has reaction changed?
6. Has awareness of diagnosis created any problems?
   Yes_____No_____
7. If yes, state the problem.
8. How would he rate the problem?
   Major__Minor__Mild___
9. Has patient tried to do something about the problem?
   Yes_____No_____
10. If yes, what did he do?
11. How effective is what he did?

b. Yes_____ No_____
If the patient does not know, ask the following questions:

1. What does he think is causing the problem?
2. Who told him and what did they say?
3. What was his initial reaction?
4. Has this reaction changed since?
   Yes___No___Don't Know___
5. In what way(s) has reaction changed?
6. Has lack of awareness of diagnosis created any problems?
   Yes_____No_____
7. If yes, state the problem.
8. How would he rate the problem?
   Major__Minor__Mild___
9. Has patient tried to do something about the problem?
   Yes_____No_____
10. If yes, what did he do?
11. How effective is what he did?

Very effective _____ Very effective _____
Not effective _____ Not effective _____
Has worsened problem _____ Has worsened problem __
Don't know _____ Don't know _____

Interviewer's Observations:

_____

_____

II. Financial Problem

a. What is patient's average monthly income?

b. Has his illness created financial problems?

c. If illness has created problems, what problems?

d. How would he rate the problem?

Major _____ Minor _____ Mild _____

e. Has patient attempted to do something about financial problem? Yes _____ No _____

f. If yes, what did he do?

g. How effective is what he did?

Very effective _____ Effective _____
Not effective _____ Worsened the problem _____
Don't know _____

Interviewer's Observations: _____

III. Patient-Doctor Relationship

a. Does patient know his doctor? Yes _____ No _____

b. Does patient feel comfortable with his doctor? Yes _____ No _____

c. Does his doctor spend enough time with patient? Yes _____ No _____

d. Does he understand his doctor? Yes _____ No _____

e. Is patient able to communicate with his doctor? Yes _____ No _____

f. What is patient's relationship with his doctor?
Very trusting _____ Trusting _____ Not Trusting _____
Has Worsened Problem _____

g. Has relationship with doctor created any problems?
Yes _____ No _____

h. If yes, what problems? _____

i. How would he rate the problem?
Major _____ Minor _____ Mild _____

j. Has patient attempted to do something about the problem? Yes _____ No _____

k. If yes, what did he do?

l. How effective is what he did? Very effective _____
Effective _____ Not effective _____
Has worsened problem _____ Don't know _____

Interviewer's Observations: _____

IV. Family Attitude

a. Is family aware of diagnosis? Yes___No___Don't Know___

b. If yes, when did family find out?	b. If family does not know what does it think is causing the problem?
c. Who told the family the diagnosis and what did they say?	c. Who told the family that and what did they say?
d. What was the family's initial reaction?	d. What was the family's initial reaction?
e. Has this reaction changed since? Yes___No___Don't know___	e. Has this reaction changed since? Yes___No___Don't know___
f. If yes, in what way(s) has it changed?	f. If yes, in what way(s) has it changed?
g. Has family's awareness of diagnosis created any problems? Yes _____ No _____	g. Has family's lack of awareness of diagnosis created any problems? Yes _____ No _____

h. If yes, state the problem.

i. How would patient rate the problem? Major___ Minor___ Mild___

j. Has patient attempted to do something about the problem? Yes _____ No _____

k. If yes, what did he do?

l. How effective is what he did?
Very effective_____
Effective_____
Not effective_____
Has worsened problem
_____
Don't know_____

h. If yes, state the problem.

i. How would patient rate the problem? Major___ Minor___ Mild___

j. Has patient attempted to do something about the problem? Yes _____ No _____

k. If yes, what did he do?

l. How effective is what he did?
Very effective_____
Effective_____
Not effective_____
Has worsened problem
_____
Don't know_____

Interviewer's Observations:_____

_____

_____

V. Psychological Problems

a. What feelings does the word cancer evoke in patient?

	Yes	No
Fear of death	_____	_____
Fear of pain	_____	_____
Fear of confinement	_____	_____
Anxiety	_____	_____
Embarrassment	_____	_____
Stigma	_____	_____
Anger	_____	_____
Guilt	_____	_____
Other (specify)	_____	_____

b. How would patient rate his feelings:
Major problem____Minor problem____Mild____

c. Has patient attempted to do something about this problem? Yes _____ No _____

d. If yes, what did he do? _____

e. How effective is what he did? Very effective _____ Effective _____ Not effective _____ Has worsened problem _____ Don't know _____

Interviewer's Observations: _____

VI. Treatment Procedure

a. What treatment is patient receiving?
Chemotherapy _____ Surgery _____ Radiation _____

b. Has treatment created any problems for patient?
Yes _____ No _____

c. If yes, state problem _____

d. How would patient rate this problem?
Major problem_____Minor problem_____Mild_____

e. Has patient attempted to do something about this problem? Yes _____ No _____

f. If yes, what did he do?

g. How effective is this?
Very effective _____ Effective _____
Not effective _____ Worsened problem _____
Don't know_____

Interviewer's Observations: _____

_____

VII. Living Arrangements

a. Are patient's present living arrangements satisfactory? Yes _____ No _____

b. If no, what causes the problem? _____

c. Do any of the following cause dissatisfaction?

	Yes	No
Space	_____	_____
Heat	_____	_____
Light	_____	_____
Privacy	_____	_____
Bathroom	_____	_____
Repairs	_____	_____
Bedding	_____	_____

Other (specify) _____

d. How would patient rate the problem?
Major problem_____Minor problem_____Mild_____

e. Has patient attempted to do something about this problem? Yes _____ No _____

f. If yes, what did he do? _____

g. How effective is this attempt? Very effective_____
Effective _____ Not effective _____ Has worsened problem _____ Don't know _____

Interviewer's observations: _____

VII. Leisure-Time Activities

a. Has the patient's illness created any problems in terms of leisure-time activities? Yes_____No_____

b. If yes, state problems _____

c. Do any of the following things cause problems?

	Yes	No
Housekeeping	_____	_____
Shopping	_____	_____
Church activities	_____	_____
Hobbies	_____	_____
Sex habits	_____	_____

Other (specify)_____

d. Has the patient's leisure-time activities increased _____, decreased_____, unchanged_____?

e. How would patient rate the problem? Major problem _____ Minor problem _____ Mild _____

f. Has patient attempted to do something about the problem? Yes _____ No _____

g. If yes, what did he do? _____

h. How effective was this? Very effective _____
Effective _____ Not effective _____ Worsened the problem _____ Don't know _____

Interviewer's observations: _____

APPENDIX B

BACKGROUND INFORMATION CARD

BACKGROUND INFORMATION

1. Case No. _____

2. Diagnosis

___1. Lung Cancer
___2. Breast Cancer
___3. Colon Cancer
___4. Stomach Cancer
___5. Cancer of the Prostate
___6. Cancer of the Pancreas
___7. Cancer of the Rectum
___8. Cancer of the Kidney
___ 9. Cancer of the Esophagus
___10. Cancer of the Larynx
___11. Cancer of the Tonsils
___12. Leukemia
___a. Acute Myelocytic
___b. Chronic Myelocytic
___13. Hodgkins Disease

3. Age _____

4. Sex: 1. Male _____ 2. Female _____

5. Race: 1. Black _____ 2. Caucasian _____ 3. Other

(specify)_____

6. Marital Status: 1. Married ___ 2. Single ___ 3. Divorced ___ 4. Separated ___ 5. Widowed ___ 6. Common-Law ___

7. Religion: 1. Protestant ___ 2. Jewish ___ 3. Catholic ___ 4. Holiness ___ 5. Other (specify) _____

8. Amount of monthly income? $_____

9. Source of income: 1. Medicaid ___ 2. General Assistance ___ 3. Social Security ___ 4. Other (specify)_____

10. Ambulatory Status: 1. Ambulatory ___ 2. Ambulatory with assistance ___ 3. Wheel chair ___ 4. Bed fast ___ 5. Cannot ascertain ___

11. Education Level: 1. Elementary School ___ 2. Junior High ___ 3. High School ___ 4. College ___ 5. Graduate School ___ 6. No formal education ___

12. Occupation _____

13. Living arrangements: 1. Lives alone ___ 2. Lives with spouse ___ 3. Lives with spouse and children ___ 4. Patient with combinations (specify)_____
_____

14. Household Size: _____

15. Special equipment at home: 1. Hospital bed ___ 2. Wheel chair ___ 3. Bedside commode ___ 4. Walker ___ 5. Other _____

16. Type of transportation: 1. Owns car ___ 2. Rides bus ___ 3. Hospital ambulance or van ___ 4. Private transportation ___ 5. Other (specify) _____

17. Duration of illness: _____

18. Leisure-time Activities: 1. Shopping ___ 2. Housekeeping ___ 3. Church Activities ___ 4. Hobbies (specify):

APPENDIX C

LETTER TO THE DIRECTOR, ONCOLOGY CLINIC, REQUESTING FOR PERMISSION TO INTERVIEW ADULT TERMINAL CANCER PATIENTS

58 Allen Temple Ct.
Apt. #203
Atlanta, Georgia
March 29, 1978

Dr. Melvin R. Moore
Director
Oncology Service
Grady Memorial Hospital
80 Butler St., S.E.
Atlanta, Georgia

Dear Dr. Moore:

I am a doctoral student at Atlanta University writing a dissertation entitled, "An Analysis of Coping Patterns of Adult Terminal Cancer Patients." As part of my research, I need to interview some of the adult cancer patients who come to the Oncology Clinic here at Grady Hospital. Please give me permission to conduct interviews with these patients. Code numbers will be used throughout the study instead of names. This information will be kept confidential and used only for the purpose of writing a dissertation.

Your cooperation will be greatly appreciated.

Sincerely,

Maxine Myers Agazie

Grady Memorial Hospital

80 Butler Street, SE, Atlanta, Georgia 30303, Telephone 404 659-1212

April 12, 1978

To Whom It May Concern:

I hereby grant permission for Maxine Agazie, a doctoral student in the School of Education, Atlanta University, to conduct interviews with adult cancer patients in Grady Memorial Hospital's Oncology Clinic. It is understood that the interviews will be conducted in a professional manner and patients' names will not be revealed. It is further understood that information gathered from the interviews will be used for a doctoral dissertation and will be held in strict confidence.

Sincerely,

Melvin R. Moore

Melvin R. Moore, M.D.
Director, Oncology Service

MRM:dw

APPENDIX D

LETTER TO THE AMERICAN CANCER SOCIETY REQUESTING FOR INFORMATION RELATING TO CANCER

58 Allen Temple Ct.
Apt. #203
Atlanta, Georgia
March 1, 1978

American Cancer Society
777 Third Street
New York, New York 10017

Dear Sir:

I am a doctoral student at Atlanta University in Atlanta, Georgia. I'm writing a dissertation entitled "An Analysis of Coping Patterns of Adult Terminal Cancer Patients."

I would appreciate you sending me any information relating to cancer that might assist me with this study.

Your compliance will be greatly appreciated.

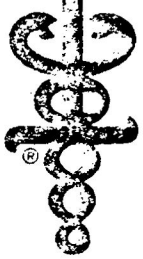
Sincerely,

Maxine Myers Agazie

AMERICAN CANCER SOCIETY, INC.

777 THIRD AVENUE • NEW YORK, N.Y. 10017 • (212) 371-2900

WILLIAM M. MARKEL, M.D.
VICE PRESIDENT FOR SERVICE
AND REHABILITATION



RESEARCH
EDUCATION
SERVICE

March 17, 1978

Ms. Maxine Agazie
58 Allen Temple Court N.W. #203
Atlanta, Georgia 30311

Dear Ms. Agazie:

In response to your request for material for your doctorate, I am enclosing some material that I hope will be helpful to you.

Sincerely yours,

Ethelyn Thomas
Secretary to Dr. Markel

encls.

BIBLIOGRAPHY

Books and Periodicals

Books

Goffman, Erving. Stigma. New Jersey: Prentice-Hall, Inc., 1963.

Hoffman, Frederick L. The Mortality from Cancer Throughout the World. New Jersey: Prudential Press, 1916.

Kubler-Ross, Elisabeth. On Death and Dying. New York: Macmillan Publishing Company, Inc., 1969.

Moos, Rudolph H. and Tsu, Vivien D. "The Crisis of Physical Illness: An Overview." Coping with Physical Illness. Edited by Rudolf H. Moos. New York: Plenum Medical Book Company, 1977.

Periodicals

Abrams, Ruth D. and Finesinger, Jacob E. "Guilt Reactions in Patients with Cancer." Cancer, 6 (May, 1953), 474-482.

Artiss, Kenneth L., and Levine, Arthus S. "Doctor-Patient Relation in Severe Illness." New England Journal of Medicine, 288 (June, 1973), 1210-1214.

Bennett, John B., and Savov, S. E. "An Experience of Cancer." Harper's Magazine, 247 (November, 1973), 97-98.

Bozeman, Mary F.; Orbach, Charles E.; and Sutherland, Arthur M. "Psychological Impact of Cancer and Its Treatment." Cancer, 8 (January-February, 1955), 1-18.

Carey, Raymond G. "Emotional Adjustment in Terminal Patients: A Quantitative Approach." Journal of Counseling Psychology, 21 (September, 1974), 433-439.

Craig, Thomas J., and Abeloff, Martin D. "Psychiatric Symptomatology Among Hospitalized Cancer Patients."

American Journal of Psychiatry, 131 (December, 1974), 1323-1327.

Dimsdale, Joel E. "The Coping Behavior of Nazi Concentration Camp Survivors." American Journal of Psychiatry, 3 (July, 1974), 792-797.

Golden, Joshua S., and Johnston, George D. "Problems of Distortion in Doctor-Patient Communications." Psychiatry in Medicine, 1 (April, 1970), 27-49.

Hayley, Harold B.; Juan, Isabel R.; and Gagan, Jean F. "Factor-Analytic Approach to Attitude Scale Construction." Journal of Medical Education, 43 (March, 1968), 331-336.

Horn, Daniel, and Waingrow, Selwyn. "What Changes Are Occurring in Public Opinion Toward Cancer: National Public Opinion Survey." American Journal of Public Health, 54 (March, 1964), 431-440.

Klagsburn, Samuel C. "Communications in the Treatment of Cancer." American Journal of Nursing, 71 (May, 1971), 944-948.

Lanzetta, John, and Driscoll, James M. "Preference for Information about an Uncertain but Unavoidable Outcome." Journal of Personality and Social Psychology, 96-102, No. 3 (1966).

Leiber, Lillian; Plumb, Marjorie M.; Gerstenzung, Martin L.; and Holland, Jimmie. "The Communication of Affection Between Cancer Patients and Their Spouses." Psychosomatic Medicine, 38 (November-December, 1976), 378-389.

McIntosh, Jim. "Process of Communication, Information-seeking and Control Association: A Collective Review of the Literature." Social Science and Medicine, 8 (April, 1974), 167.

Peck, Arthur, and Boland, John. "Emotional Reactions to Radiation Therapy." Cancer: A Journal of the American Cancer Society, 40 (July, 1977), 180-184.

Perlman, Helen H. "In Quest of Coping." Social Casework, 56 (April, 1976), 213.

Pinkerton, Susan S., and McAleer, Charles. "Influence of Client Diagnosis-Cancer on Cancer Counselor Decision." Journal of Counseling Psychology, 23 (1976), 575-578.

Quint, Jeanne C. "The Impact of Mastectomy." American Journal of Nursing, 63 (November, 1963), 88-92.

Rothenberg, Albert. "Psychological Problems in Terminal Cancer Management." Cancer, 14 (September-October, 1961), 1063.

Sanders, Judith B., and Kardinal, Carl G. "Adaptive Coping Mechanisms in Adult Acute Leukemia Patients in Remission." Journal of the American Medical Association, 238 (August, 1977), 952-954.

Schwartz, Doris. "Nursing Needs of Chronically Ill Ambulatory Patients." Nursing Research, 9 (Fall, 1960), 185.

Sotsky, Harold V., and Hamburg, David. "Coping Behavior Under Extreme Stress." Archives of General Psychiatry, 5 (1961), 432-448.

Wolff, Ilse S. "Should the Patient Know the Truth?" American Journal of Nursing, 55 (May, 1955), 546.

Worby, Cyril M., and Babineau, Raymond. "The Family Interview: Helping Patient and Family Cope with Metastatic Disease." Geriatrics, 29 (June, 1974), 83-90, 94.

World Book Encyclopedia, 1968, ed. S. V., "Cancer," by Kenneth M. Endicott.

Reports and Papers

Reports

Dyk, Ruth B., and Sutherland, Arthur. "Adaptation of the Spouse and Other Family Members to the Colostomy Patient." The Psychological Impact of Cancer. Professional Education Publishing by the American Cancer Society (1974), 72-87.

Grady Memorial Hospital. "Principles of Practice for the Medical Oncology Clinic." A Memorandum Distributed to the Staff of the Oncology Clinic.

Hayes, Donald M. "The Impact of the Health-Care System on Physician Attitudes and Behaviors." Cancer: The Behavioral Dimensions, ed. by J. W. Cullen, B. H. Fox, and R. N. Isom, U.S. Department of Health, Education and Welfare National Institute of Health Publication No. 76-1074, p. 1-169.

Holland, Jimmie C. "Coping with Cancer: A Challenge to the Behavioral Sciences." Cancer: The Behavioral Dimensions, ed. by J. W. Cullen, B. H. Fox, and R. N. Isom, U.S. Department of Health, Education and Welfare National Institute of Health Publication No. 76-1074, pp. 3-19.

Krant, Melvin J. "Problems of the Physicians in Facing the Patient with the Diagnosis." Cancer: The Behavioral Dimensions, ed. by J. W. Cullen, B. H. Fox, and R. N. Isom. U.S. Department of Health, Education and Welfare National Institute of Health Publication No. 76-1074, p. 3-9.

The Fulton-DeKalb Hospital Authority. Grady Memorial Hospital Policies and Procedures Manual (July, 1977-1978), p. 1.

Vettese, Joann. "Problems of the Patient Confronting the Diagnosis of Cancer." Cancer: The Behavioral Dimensions, ed. by J. W. Cullen, B. H. Fox, and R. N. Isom, U.S. Department of Health, Education and Welfare National Institute of Health Publication No. 76-1074, p. 3-19.

Weisman, Avery D. "Coping Behavior and Suicide in Cancer." Cancer: The Behavioral Dimensions, ed. by J. W. Cullen, B. H. Fox, and R. N. Isom. U.S. Department of Health, Education and Welfare National Institute of Health Publication No. 76-1074, p. 3-9.

Paper

Lepper, Kathleen E. "Problems and Coping Patterns of the Household Member Caring for the Adult Female Cancer Patient in the Home." Ed.D. dissertation, Columbia University, 1968.